

00-02203

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 3 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ethel E. HARKIS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/23/86 |   |  | 2b. HOUR<br>5:50 AM   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 5 04  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Towson Baltimore County MD                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dulany Towson Nursing Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaking  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>7930 Rolling View Ave. 21236   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Funk   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amelia Nowall  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217-18-9237   |  | 17. INFORMANT<br>ADDRESS<br>Eileen D. Volker 7930 Rolling View Rd. 21236  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (If this hospital) attended the deceased from <u>3/10/86</u> to <u>3/23/86</u> , that (I) (we) last saw the deceased alive on <u>3/23/86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>M. Smith</u>  |  |   |  | DEGREE<br>MD  |  |   |  | 22c. DATES SIGNED<br>3/24/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Meredith Smith, MD (435-5459)   |  |   |  | 22e. ADDRESS<br>1900 E. Northern Parkway Balto., Md.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3-26-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Stasolu 714 7401 Belair Rd.</u>   |  |   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br>MAR 27 1986   |  |  |  |

BP

30750-00

00-01375

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 3 8

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Harmon H. Harris</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 25 86</b>   |   | 2b. HOUR<br>M<br><b>M</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 7 13</b>   |   | 6. AGE [IN YEARS LAST BIRTHDAY]<br><b>72</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.            |
| 7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY]<br><b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>30 Ridge Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired-Comm. Supv.-Bendix Corp.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             | 13e. STREET ADDRESS<br><b>Baltimore, Md.<br/>30 Ridge Rd. #21228</b>                      |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Herbert Harris</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leola Gertrude Harman</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   IF YES, GIVE WAR OR DATES<br><b>Yes</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>-4346A<br/>216-07-4396A</b>  |   | 17. INFORMANT<br><b>30 Ridge Road - Baltimore, Md.<br/>Marcelle G. Harris #21228</b>      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal Cell Carcinoma of Kidney</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastases to neck &amp; brain</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 months<br/>6 weeks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |   |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>Aug '85</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Removal of kidney - abou</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   |   |   |
| 21b. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21c. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 6</b> , 19 <b>86</b> , to <b>Mar 24</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>Mar 24</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Robert Z. Berry</b>  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3/26/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Z. BERRY</b>   |   | 22e. ADDRESS<br><b>5550 Baltimore Nat'l Pk</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>Mar. 27, 1986</b>   |   | 23c. NAME OF GEMETERY OR CREMATORY<br><b>Garrison Forest Vets. Cem. Owings Mills, Md.</b> |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Truman Schwab</b>   |   | ADDRESS<br><b>3151 Balto. Nat'l Pk<br/>Baltimore, Md. #21229</b>  |   | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>  |   |
| 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |   |   |   |

BP





00-016331

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |  |  |  |  |   |  |   |  |  |  |            |  |           |  |
|---|---------|--|--|--|--|---|--|---|--|--|--|------------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH                                       |  |  |  | 2b. HOUR   |  |           |  |
| ELIJAH  |         |  |  | HARVIN   |  |   |  | DATE ESTIMATED <input checked="" type="checkbox"/> 3 25 19 86 |  |  |  | 3 25 19 86 |  |           |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD                     |  |            |  | 2d. HOUR  |  |
| male  | black   | 7 23 1925  |  | 60 YRS.  |  |   |  |   |  | 3 25 19 86                                   |  |            |  | 7:33 P.M. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |  |  |            |  |           |  |
| S.C.  |         | U S A  |  |  |  | Baltimore County  |  |   |  |  |  |            |  |           |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |  |  |            |  |           |  |
| Woodlawn  |         | 5515 Rhom Rd.  |  | RETIRED  |  | steel   |  |   |  |  |  |            |  |           |  |
| 13a. STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |  |  |            |  |           |  |
| Md  |         | BALTO.   |  | Woodlawn   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 3515 Rhom Road  |  | 21207  |  |            |  |           |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS                                      |  |            |  |           |  |
| Frank   |         | Ellen  |  | Yes  |  | 249-32-0762   |  | Rosa Harvin   |  | 3515 Rhom Road                               |  |            |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | Arteriosclerotic cardiovascular disease                             |  | DUE TO, OR AS A CONSEQUENCE OF                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |            |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |         | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (c)   |  |   |  |  |  |            |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I - a. |         |  |  |  |  |   |  |   |  |  |  |            |  |           |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |            |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |   |  |  |  |            |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK     |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |            |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                      |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                       |  |   |  |   |  |  |  |            |  |           |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |  | M.D. Assistant   |  | MEDICAL EXAMINER  |  | DATE SIGNED   |  | 3-26-86                                      |  |            |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | Ann M. Dixon, M.D.   |  | ADDRESS  |  | 111 Penn St., Balto., MD  |  | 21201   |  |  |  |            |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN  |  | COUNTY                                       |  | STATE      |  |           |  |
| Burial  |         | 4/1/86   |  | Woodlawn Cemetery  |  | Balto   |  | Co  |  | Md   |  |            |  |           |  |
| 24. FUNERAL DIRECTOR  |         | NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                    |  |  |  |            |  |           |  |
| William C. March F/H West   |         | 4300 Wabash Avenue   |  |  |  |   |  |   |  |  |  |            |  |           |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. A DEATH FORM, PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT DEATH PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH - 17  
(VR A15 ME (1))

MAR 31 1986



00-01903

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |                             |  |
|--|--|---|---|--|-----------------------------|--|
| 1. DECEASED NAME<br>(LAST, FIRST, MIDDLE)<br><b>Nannie Haskins</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 25 86</b> |  | 2b. HOUR<br><b>245 A.M.</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPTEMBER 27, 1915</b>  |                             |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |   | 8. IF UNDER 74 HRS<br>HOURS MIN.<br><b>YRS.</b>  |                             |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>   |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD.   |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SPRING GROVE HOSPITAL CENTER</b>  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>NONE</b>                               |                             |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   |  | 13a. STREET ADDRESS<br><b>WADE AVENUE</b>   |   | 13b. CITY OR TOWN<br><b>21228</b>  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN BARNES</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SARAH BELK</b>  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |                             |  |
| 17. SOCIAL SECURITY NO.<br><b>577-05-4950</b>  |  | 18. INFORMANT<br><b>JAMES CUNNINGHAM, SON, 718 CHILLUM RD.,</b>   |   | 19. ADDRESS<br><b>HYATTSVILLE, MD.</b>   |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bilateral pulmonary metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of breast</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b><br><b>4 years</b> |  |   |   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>   |  |   |   |  |                             |  |
| 19a. DATE OF OPERATION<br><b>1981, 1982</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Mas</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |                             |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N.A. 19</b>  |                             |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>N.A.</b>  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                       |                             |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>10/21</b> 19 <b>81</b> , to <b>3/25</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.) |   | 22b. SIGNATURE<br><b>Mack Bonner, Jr.</b>  |                             |  |
| 22c. PHYSICIAN'S NAME<br><b>Mack Bonner, Jr.</b>   |  | 22d. ADDRESS<br><b>Spring Grove Hospital, Catonsville, Md.</b>  |   | 22e. DATE SIGNED<br><b>3/25/86</b>   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>3/26/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>METROPOLITAN CREMATORY</b>  |                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ALEXANDRIA VIRGINIA</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>RICHARD RAPP, INC.</b><br><b>1804 T ST., N.W., WASHINGTON, D.C. 20009</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 31 1986</b>  |                             |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |  |                             |  |

MEDICAL CERTIFICATION

2  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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00-00638

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 06941

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |   |  |  |  |
|--|--|---|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ida Hamlin Haus   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>March 13, 1986                   |  |  | 2b HOUR<br>M   |   |  |  |  |
| 3 SEX<br>F   |  | 4 RACE<br>W   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>August 10, 1898   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS   |   | 7a UNDER 1 YEAR<br>MONTHS DAYS<br>7b IF UNDER 74 HRS<br>HOURS MIN.   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co., MD.                            |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Owings Mills   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baptist Home of Maryland |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker         |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>Md.  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>3839 Monterey Road 21218 |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Everett Johnson, Jr.   |  |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Frances B. Birkhead  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>- - - - -    |  | 17 INFORMANT<br>ADDRESS<br>Baptist Home of Maryland Owings Mills, Md.  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) METASTATIC BLADDER CANCER<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 MONTHS   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>ANEMIA   |  |   |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |
| 22a I certify that (I) (the hospital) attended the deceased from JULY 1981 to MARCH 1986, that (I) (last saw the deceased alive on) MARCH 6 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>John J. Lavin  |  |   |  |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br>3-14-86  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN LAVIN  |  |   |  |  | 22e. ADDRESS<br>6805 YORK RD; BALT. MD.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>3/15/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 18 1986   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the folder and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, view any injury, or other traumatic event.



00-006786

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 4 2

REG. NO.

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Peggy Ellen Hayworth</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 16 1986</b> |   |  | 2b. HOUR<br><b>9:50AM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 28 1924</b>   |  | 6. AGE<br>IN YEARS (LAST BIRTHDAY)<br><b>61</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cancer Research</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Government</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Rockdale</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3526 Saint James Road 21207</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence McLean Hayworth</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ellen Ware</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-20-8092</b>   |   | 17. Mr. Craig Blackburn<br>ADDRESS<br><b>40 Summerfield Road Baltimore Maryland</b>   |  | 21207   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Dehydration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cancer of lung &amp; metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>to the Brain</u> |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)<br><u>Anaemia</u>  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/16/1986</u> to <u>1986</u> , that (I) (we) last saw the deceased alive on <u>3/16/1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>F. Kawaja</u>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>3/16/86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>TAHOORA KAWAJA</u>  |  |   |   | 22e. ADDRESS<br><u>8204 Liberty Rd Baltimore MD 21207</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-18-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olive Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Baltimore Maryland</b>            |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b><br>ADDRESS<br><b>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAR 18 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Wendell</u>  |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. These pages must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





00-01630

1-  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 4 3

REG. NO.

|  |  |  |   |   |   |  |   |  |  |
|--|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Earl Oscar Heaton</b>  |  |  | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 27, 1986</b>        |   |   | 7b. HOUR<br><b>2 A.M.</b>  |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 8, 1896</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>   |   | 6. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Potsdam, N.Y.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>711 Maiden Choice Lane</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Capt. USCGS</b>                                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Govt. Survey</b> |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>                                     |   | 13c. CITY OR TOWN<br><b>Catonsville</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles -- Heaton</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ada -- Ames</b> |   |   | 16. STREET ADDRESS / ZIP CODE<br><b>711 Maiden Choice Lane 21228.</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |   | 17. INFORMANT<br><b>Glenn E. Heaton</b>   |   | 17. ADDRESS<br><b>Baltimore, Md. 21217.</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b>   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>gastrointestinal Hemorrhage</b>   |   | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD.</b>   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):   |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 19 86</b> , to <b>March 27 86</b> , that (I) (we) lost<br>saw the deceased alive on <b>February 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death |  |  |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>K Kessler-Taub MD</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 22c. DATE SIGNED<br><b>3/28/86</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K Kessler-Taub MD</b>  |  | 22e. ADDRESS<br><b>405 Frederick Rd Catonsville Md</b>   |   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>3/28/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Sterling Funeral Estate, P.A.</b>   |  | ADDRESS<br><b>736 Edmondson Ave.; Catonsville, Md. 21228.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 31 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |  |  |

MEDICAL CERTIFICATION

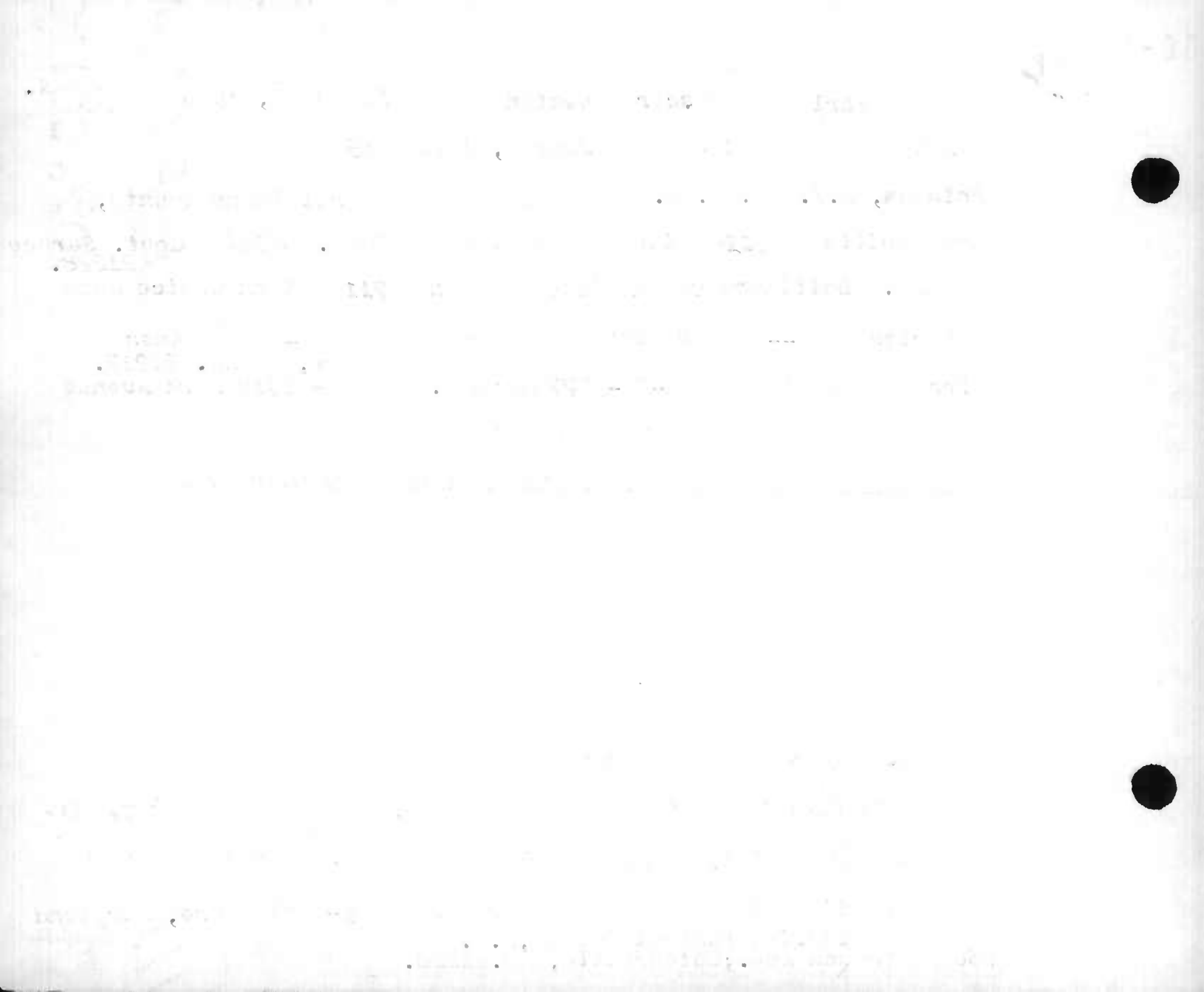
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_



0-02615

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 4 4

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Louise D. Hecsko</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>31</b> YEAR <b>86</b> |   |  | 2b. HOUR<br><b>1:35P</b> M  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>29</b> YEAR <b>1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Valley Nursing &amp; Convalescent Ct.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>30. STATE<br><b>Maryland</b> |  | 13b. COUNTY<br><b>Harford</b>   |  | 13c. CITY OR TOWN<br><b>Jarrettsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Alfonso</b> MIDDLE <b>DeBellis</b> LAST <b>DeBellis</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Emilia</b> MIDDLE <b>Porazzi</b> LAST <b>Porazzi</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>207-01-1470</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Victor LaBate 4053 Federal Hill Rd. 21084</b>  |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ischemic Coronary Artery Disease</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a  
**Cerebral Hemorrhage**

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

|   |  |                     |  |  |  |                                   |  |
|---|--|---------------------|--|--|--|-----------------------------------|--|
| 22b. SIGNATURE<br><b>Marion Kowalewski</b>                        |  | DEGREE<br><b>MD</b> |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-1-86</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marion Kowalewski</b> |  |                     |  | 22e. ADDRESS<br><b>8604 Harford Road 21234</b>   |  |                                   |  |

|  |  |                            |  |   |  |  |  |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>4/3/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Union Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Hellertown</b> STATE <b>Northampton Pa.</b> |  |
|--|--|----------------------------|--|---|--|--|--|

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME <b>Mitchell-Wiedefeld</b> ADDRESS <b>6500 York Rd.</b> |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 04 1986</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b> |  |
|---|--|--|--|---|--|--|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

3-21-52 10:00 AM

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064052

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 06945

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |  |  |   |   |  |
|---|--|---|---|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARION O. HEILMAN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 1 86</b>                      |  |  | 2b. HOUR<br><b>2150 M</b>  |  |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 30, 1933</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD   |  |   |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. Gen. Hosp.</b> |   |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Groom</b>  |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Race horses</b>  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br><b>Ind.</b>  |  |   | 16b. COUNTY<br><b>Balto.</b>  |  | 16c. CITY OR TOWN<br><b>Glyndon</b>                          |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 18. STREET ADDRESS / ZIP CODE<br><b>4247 Butler Rd. 21071</b> |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert O. Heilmann</b>   |  |   | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>TheLma C. Travers</b> |  |  | 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>                                   |  |   |   |  |
| 22. SOCIAL SECURITY NO.<br><b>215-32-8869</b>   |  |   | 23. INFORMANT<br><b>Robert L. Heilman</b>                                 |  |  | 24. ADDRESS<br><b>4247 Butler Rd. Glyndon, Md. 21071</b>   |  |   |   |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>STREPTOCOCCAL SEPTICAEMIA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>PNEUMONIA, METABOLIC ENCEPHALOPATHY.</b>   |  |   |   |  |  |  |  |   |   |  |
| 26. DATE OF OPERATION   |  |   | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |  |  | 28. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 31. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>          |  |  | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |  |
| 33. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 34. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |  |  | 35. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 36. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                     |  |   |   |  |  |  |  |   |   |  |
| 37. SIGNATURE<br><b>Hafeez A. Syed MD</b>   |  |   | 38. DEGREE<br><b>MD</b>   |  |  | 39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 40. DATE SIGNED<br><b>3/1/86</b>  |   |  |
| 41. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFAEEL A SYED MD</b>  |  |   | 42. ADDRESS<br><b>BALTIMORE COUNTY GEN HOSP</b>                           |  |  |  |  |   |   |  |
| 43. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>BURIAL</b>   |  |   | 44. DATE<br><b>3/4/86</b>   |  | 45. NAME OF CEMETERY OR CREMATORY<br><b>Emory Chapel Cem</b> |  | 46. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Upperco, Maryland.</b>                         |   |   |  |
| 47. FUNERAL DIRECTOR<br>NAME<br><b>N. J. Schandt</b>  |  |   | 48. ADDRESS<br><b>Owings Mills, Md</b>                                    |  |  | 49. DATE REC'D BY REGISTRAR<br><b>MAR 3 1986</b>   |  | 50. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP





00-01354

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 06946

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Jeannette V. Heller</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 23 86</b>                  |  |  | 2b HOUR<br>MIN.<br><b>1140 A</b>   |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 10, 1922</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>63</b>                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                       |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beautician</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a STATE<br><b>Maryland</b>   |  |  | 13b COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Lutherville</b>                    |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br><b>6 Croftley Rd. 21093</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry T. Wilson</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Pauline Dixon</b> |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-12-4432</b>   |   | 17 INFORMANT ADDRESS<br><b>Ben Heller - Same as #13e</b>   |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lung Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)           |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>3/21</b> 19 <b>86</b> to <b>3/23</b> 19 <b>86</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>3/23</b> 19 <b>86</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did (did not) view the body after death. |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>K R Faulkner MD</b>   |  |  |   |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kendall R. Faulkner, M.D.</b>  |  |  |   |  |  | 22e ADDRESS<br><b>Stella Maris Hospice<br/>2300 Dulany Valley Rd. - Towson, MD 21204</b> |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b DATE<br><b>3-26-86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto., Md.</b>                  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |  |   |  |  | ADDRESS<br><b>1050 York Rd.</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>   |  |  |
| 25b REGISTRAR'S SIGNATURE  |  |  |   |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

RECEIVED  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535



00-00281

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 4 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                               |  |  |
|--|--|--|--|---|-------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Henrietta</b> <sup>FIRST</sup> <b>W.</b> <sup>MIDDLE</sup> <b>HENNEGAN</b> <sup>LAST</sup>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> / DAY <b>10</b> / YEAR <b>86</b> |   | 2b. HOUR<br><b>5:30</b> P. M. |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> / DAY <b>15</b> / YEAR <b>102</b>  |                               | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b><br>YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  |   |                               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Balto., Md.</b>   |                               | 13d. STREET ADDRESS / ZIP CODE<br><b>216 Gaywood Rd. 21212</b>   |  |
| 14. FATHER'S NAME<br><b>John</b> <sup>FIRST</sup> <b>Wilson</b> <sup>MIDDLE</sup>  |  | 15. MOTHER'S MAIDEN NAME<br><b>Frances</b> <sup>FIRST</sup> <b>DeSoto</b> <sup>MIDDLE</sup> <b>Maccubbin</b> <sup>LAST</sup>             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b><br>(IF YES, GIVE WAR OR DATES)   |                               |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-26-2651 A</b>   |  | 17. INFORMANT<br><b>Joseph E. Hennegan</b> ADDRESS <b>1524 Norman Ave. 21093</b><br><b>Lutherville, Md.</b>                              |  |   |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Post cerebral cardiovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |  |  |   |                               |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> , 19 <b>84</b> , to <b>3/10</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                               |  |  |
| 22b. SIGNATURE<br><b>Dr. Faulkner</b> <sup>DEGREE</sup> <b>MD</b>  |  | 22c. DATE SIGNED<br><b>3/10/86</b>   |  |   |                               | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR KENDALL FAULKNER</b>  |  |
| 22e. ADDRESS<br><b>Balto., Md. 21212</b>   |  | 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  |   |                               |  |  |
| 23b. DATE<br><b>3/13/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balto. Md.</b>  |                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld</b>  |  | 6500 York Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>   |                               | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |



00-016222

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 4 8

REG. NO.

|  |  |   |  |   |  |  |   |  |  |  |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Helen Aldene Henshaw</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 30, 1986</i>           |   | 2b. HOUR<br>A. <i>6:15</i><br>M.   |  |   |  |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 24 25</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><i>61</i>                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Eastwood</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>7058 Eastbrook Avenue</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housework</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>At Home</i>  |  |  |
| 13a. STATE<br><i>Maryland</i>  |  |   | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Eastwood</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>7058 Eastbrook Avenue 21224</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John Baldwin</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Elva McGlumphy</i> |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  |   | 16b. SOCIAL SECURITY NO.<br><i>219-22-9013</i>                         |   | 17. INFORMANT<br>ADDRESS<br><i>Edward C. Henshaw 7058 Eastbrook Ave. 21224</i>   |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i><br><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>widely metastatic breast cancer</i><br><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 1/2 years</i>   |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>0</i>   |  |  |
|  |  |   |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>December</i> 19 <i>83</i> , to <i>March</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>March 18</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Scott H. Kaufmann</i>   |  |   |  |   | DEGREE<br><i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>3/31/86</i>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Scott H. Kaufmann, M.D.</i>  |  |   |  |   | 22e. ADDRESS<br><i>600 N. Wolfe Street, Baltimore, Maryland</i>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  |   | 23b. DATE<br><i>4-1-86</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eastwood, Balto. Co., Md.</i>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</i>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 31 1986</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Wanda Davidson-Hendall</i>                                     |  |  |  |

2005-04-15

00-02737

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8606949  |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FREDERICK L. HESSENAUER</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MARCH 30, 1986</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 5 10</b>   |  |
| 7a. BIRTHPLACE<br>(COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Kuxton 7001 N. Charles St.</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sealtest Foods</b>  |  |
| 13a. STREET ADDRESS / ZIP CODE<br><b>13331 Fork Rd. 21013</b>   |  |   |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Adam HESSENAUER</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Martha BOPP</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-10-3741</b>  |  | 17. INFORMANT<br>ADDRESS <b>21013 Patricia A. Vendetti 6012 Fork Woods Rd.</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Anemia</b> |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>FEB. 19 86</b> to <b>MARCH 26 19 86</b> , that (I) (we) last saw the deceased alive on <b>MARCH 26 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Gracito Patricio, M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>4/1/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gracito Patricio, M.D. (254-0392)</b>   |  |   |  | 22e. ADDRESS<br><b>2926 E. Cold Spring Lane Balto. Md. 21214</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>4-2-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>KINGSVILLE, MD. 21087</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>   |  | 23e. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |
| E. F. Lassahn Funeral Home 11750 Belair Rd. APR 4 1986  |  |   |  |   |  |



RECEIVED  
JAN 10 1961  
FBI  
WASHINGTON

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows]

*[Handwritten signature]*

*[Handwritten initials]*

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above. The letterhead memorandum is being furnished to the Bureau for its information and for its use in the event of a need for further information.

00-01629

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8606950

REG. NO.

|   |   |   |  |   |                                   |
|---|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SHIRLEY HESTER   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 28 86  |  | 2b. HOUR<br>0654A   |                                   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 8 32  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Canada   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |                                   |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. Co. Gen. Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Lady |   | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>Md.   |   | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Owings Mills  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wilfred Ellis   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Smith   |  | 13e. STREET ADDRESS / ZIP CODE<br>26 K Deer Lodge Ct. 21117   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-54-5153  |  | 17. INFORMANT<br>ADDRESS<br>Melody TALL 4719 Central Dr. N.E. Stone Mountain, GA 30083  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>SHOCK</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>HEPATORENAL FAILURE</u>   |   |   |  |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ABDOMINAL MASS, RT. PARANILAR MASS, ABCITES, OAT CELL CA.</u>   |   |   |  |   |                                   |
| 19a. DATE OF OPERATION<br>3/24/86   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>RT. PARANILAR MASS.   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>(above, (I) (we) (did) (did not) view the body after death) |   |   |  |   |                                   |
| 22b. SIGNATURE<br>Hafeez A. Syed  |   | DEGREE  |  | 22c. DATES SIGNED<br>3/28/86  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HAFAEEZ A SYED   |   | 22e. ADDRESS<br>BALTIMORE COUNTY GEN. HOSPITAL  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |   | 23b. DATE<br>3/31/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. PK.   |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |   | 23e. DATE REC'D. BY REGISTRAR<br>MAR 31 1986  |  | 23f. REGISTRAR'S SIGNATURE<br>[Signature]   |                                   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>N. J. Schmitt Owings Mills, Md.   |   |   |  |   |                                   |

MEDICAL CERTIFICATION

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after a death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2008 COLLECTION

DND

2008 COLLECTION

00-00674

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 5 1

REG. NO.

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Laura</b>  |  |  | FIRST MIDDLE LAST <b>Hewitt</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>March 16 1986</b>   |  |  | 2b. HOUR <b>M</b>  |  |  |
| 3 SEX <b>Female</b>   |  |  | 4 RACE <b>Cauc.</b>  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 10 12</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Ft. Howard</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS) <b>9232 Howard Ave.</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE <b>Md.</b>   |  |  | 13b. COUNTY <b>Balto.</b>  |  |  | 13c. CITY OR TOWN <b>Ft. Howard</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>William Wilson</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Delie Hover</b>  |  |  | 13e. STREET ADDRESS / ZIP CODE <b>9232 Howard Ave. 21052</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>173-12-1993</b>  |  |  | 17. INFORMANT ADDRESS <b>Eugene Pierelli Suite 227-1107 North Pt. Rd.</b>   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b><br><b>10 yrs.</b><br><b>Since childhood</b> |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Dilated Neck</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/26</b> , 19 <b>79</b> , to <b>3/15</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Randall E. Cronin, Jr.</b> DEGREE <b>M.D.</b>   |  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |  | 22c. DATE SIGNED <b>3/17/86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Randall E. Cronin, Jr.</b>   |  |  |  |  |  | 22e. ADDRESS <b>741 Wheeler School Rd. Whiteford Md.</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |  | 23b. DATE <b>3/19/86</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>  |  |  |
| 24 FUNERAL DIRECTOR NAME <b>Connelly Funeral Home</b> ADDRESS <b>305 Dundalk Rd. 21221</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 19 1986</b> 25b. REGISTRAR'S SIGNATURE <b>Jane Anderson-Randall</b>  |  |  |  |  |  |

MEDICAL CERTIFICATION

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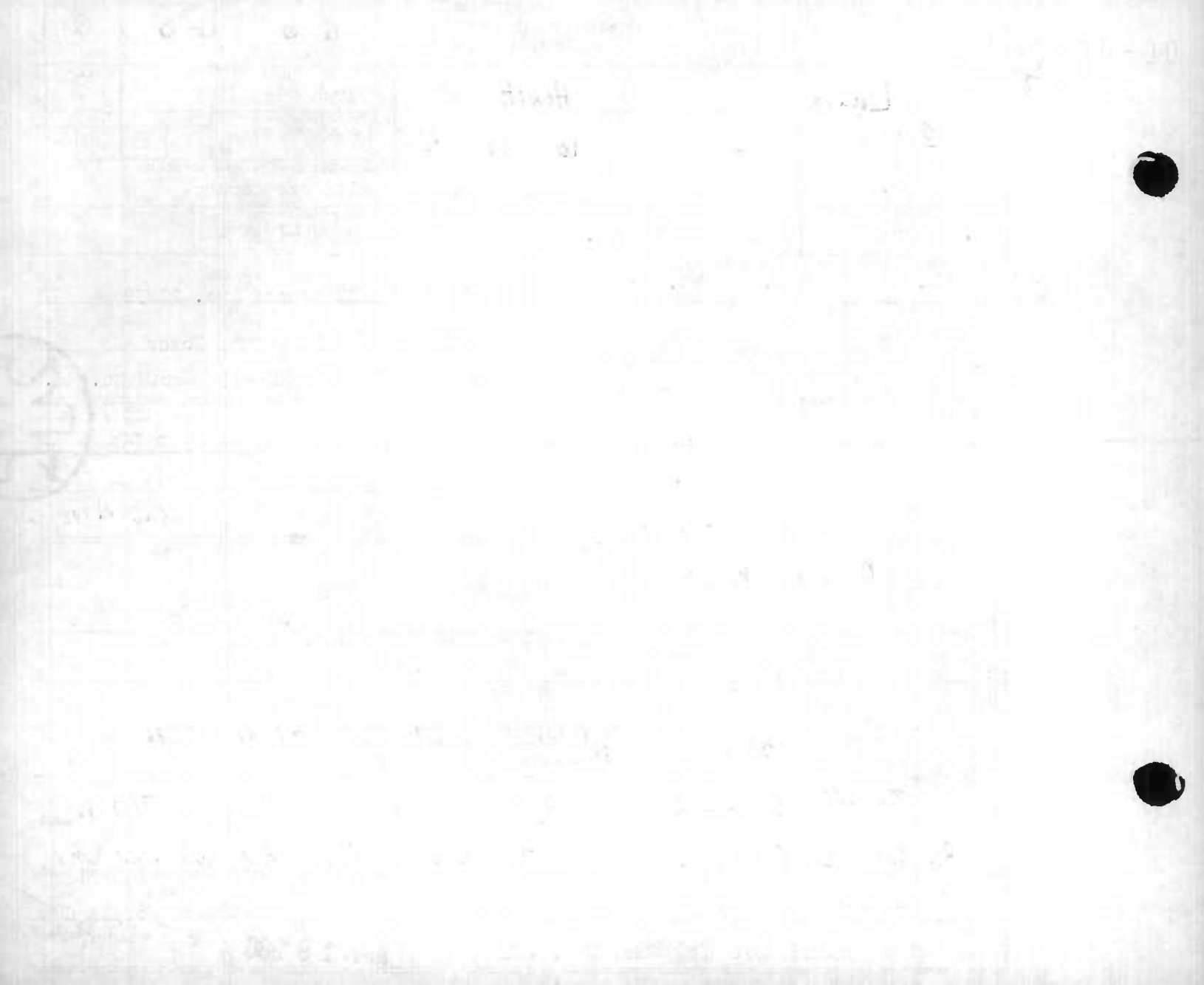
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-01624

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                            |  |
|--|--|--|--|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Myrtle A. Hildebrandt</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 26, 1986</b> |   | 2b. HOUR<br><b>11:05pm</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 4, 1895</b>                                       |                            |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |                            |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Oliver Beach</b>  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Sawyer</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maryann Spencer</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-07-2641</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Wanda Hill 514 B Carrollwood Rd. 21220</b>                  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic obstructive pulmonary disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (this hospital) attended the deceased from <b>March 26, 1986</b> to <b>March 26, 1986</b> , that (we) last saw the deceased alive on <b>March 26, 1986</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) die in the body after death.  |  |  |  |   |                            |  |
| 22b. SIGNATURE<br><b>John Merwin MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>3-26-86</b>  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Merwin, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-29-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                   |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   |  |   |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Md.</b>  |  |  |  |   |                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MAR 31 1986

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-11-2010 BY 60322 UCBAW

Legend J. Moore, Inc., Baltimore, Md.  
2-02-50  
Baltimore of Baltimore, Md.  
Baltimore, Maryland



00-00667

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 5 3

REG. NO.

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Charles R. Hill   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 6, 1986                   |   |  | 2b. HOUR<br>5:00AM   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 26, 1927  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Parkton   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1748 Parsonage Rd. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Contractor   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Parkton  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1748 Parsonage Rd. 21120   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Felix Reid Hill  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Mae McMillan   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | (IF YES, GIVE WAR OR DATES)<br>WWII   |  | 16b. SOCIAL SECURITY NO.<br>220-20-6452   |  | 17. INFORMANT<br>Betty J. Hill   |  | 17a. ADDRESS<br>1748 Parsonage Rd.<br>Parkton, MD 21120   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of the lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 85</u> to <u>March 6<sup>th</sup> 86</u> , that (I) (we) lost<br>saw the deceased alive on <u>Jan. 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>G. Bedon MD</u>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/10/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE BEDON MD   |  |   | 22e. ADDRESS<br>660 Kemilworth Drive Balto 21204                       |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>March 8, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Pine Grove Cemetery Parkton, Baltimore, MD |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J.J. Hartenstein   |  |   | Second at Franklin St.<br>New Freedom, PA 17349                        |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1986   |  | 25b. REGISTRAR'S SIGNATURE  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove couplet papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



072169

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 5 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELEANOR L. HILTON</b>                   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 9 86</b>                                 |   | 2b. HOUR<br><b>11:10A M</b>   |
| 3 SEX<br><b>Female</b>  | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 17, 1890</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b><br>YRS MONTHS DAYS HOURS MIN.      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.             |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES STREET</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>   |   |   | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Olney</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Meidling</b>                    |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Hager</b>                   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-74-8007</b>   |  | 17. INFORMANT ADDRESS<br><b>Maryland Masonic Homes, Cockeysville, Md. 21030</b> |   |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO RESPIRATORY ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**HRS**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lastDUE TO, OR AS A CONSEQUENCE OF  
(b) **CARDIAC DISEASE****YEARS**DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**URINARY TRACT INFECTION**

MEDICAL CERTIFICATION

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-7</b> 19 <b>86</b> to <b>3-9</b> 19 <b>86</b> , that (I) (we) last<br>saw the deceased alive on <b>3-9</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If I/we did) did not view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>J.W. Wernicki</b>   |  | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J.W. WERNICKI, M.D.</b>  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES STREET</b>                                   |   |

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                  | 23b. DATE<br><b>March 12, 1986</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b> |                                    | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 11 1986</b> <i>James Davidson Handell</i> |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

C-1370



00-01297

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 4 5 5

REG. NO.

|  |  |  |   |   |                                   |   |
|--|--|--|---|---|-----------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lawrence W. Hines</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-21-86</b> |   | 2b. HOUR<br>MIN.<br><b>6 20 M</b> |   |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 25 1893</b>  |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b><br>YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Nursing Home-Towson</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-Employed</b>  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farmer</b>  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Towson</b>  |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Uriel B. Hines</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida Doris Kirkdall</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |                                   |   |
| 16b. SOCIAL SECURITY NO.<br><b>220-44-7032A</b>  |  | 17. INFORMANT ADDRESS<br><b>Chester Hobbs 10015 Magledt Rd. 21234</b>  |   |   |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia, lobar recurrent 2 wks</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Corrhythmia Controlled c Pacemaker</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senile Dementia Mild</b> |  |  |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |   |                                   |   |
| 19a. DATE OF OPERATION<br><b>Jan 19 68</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Prostatectomy</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, PARKING OFFICE, FARM, ETC.)<br><b>Jan 19 68</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7401 Belair Rd. BALTO. MD. 21236</b>  |                                   |   |
| 22. I certify that (1) (this hospital) attended the deceased from <b>Jan 19 68</b> to <b>Mar 19 86</b> that (1) (the last saw the deceased alive on <b>Mar 19 86</b> ) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (reluctant) view the body after death.  |  |  |   |   |                                   |   |
| 22a. SIGNATURE<br><b>Dr. Kasik</b>   |  | 22b. ADDRESS<br><b>665-8692</b>  |   | 22c. DATE SIGNED<br><b>3/21/86</b>  |                                   | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-24-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |  | 24a. ADDRESS<br><b>7401 Belair Rd. BALTO. MD. 21236</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 25 1986</b>   |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

*[Faint, mostly illegible text and markings on lined paper, possibly bleed-through from the reverse side. Some words like "Lithium" and "Sulfate" are partially visible.]*

00-02039

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 5 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Maria K.F. Hinze</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 18, 1986</b>                             |   | 2b. HOUR<br><b>6:50</b><br>P M                                  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 16, 1900</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b><br>YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b><br>MD                            |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cockeysville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Broadmead</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Social Worker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical</b>             |
| 13a. STATE<br><b>New York</b>  |   | 13b. COUNTY<br><b>Kings</b>  | 13c. CITY OR TOWN<br><b>Brooklyn</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Lee Fulton</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Davis</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>066-16-3353A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Frederic F. Hinze - 314 Edgerale Rd. - 31210</b>                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebrovascular Accident with Coma</b> |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>ISCHEMIC HEART DISEASE, Low Pressure Hydrocephalus</b>  |   |  |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |  |  |   |   |
| 22b. SIGNATURE<br><b>Walter R. Hepner, III</b>   |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>3/19/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Walter R. Hepner, III M.D.</b>   |   | 22e. ADDRESS<br><b>3303 Paper Mill Rd.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>Mar. 22, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gunpowder Friends</b>                                  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sparks, Baltimore Co., Maryland</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Car Davidson-Randall</b>  |   |  |  |   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOTICE

Handwritten notes and signatures, including a large 'C' and 'J'.





00-01159

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8606957

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |   |  |  |  |
|--|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George Harry HOCK   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 19 1986   |   |  | 2b. HOUR<br>1:47 p.m.   |   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 26, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                      |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rosedale  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Grocer - Ret. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Groceries   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>---   |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>32 N. Lakewood Ave. 21224. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jacob P. Hock  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>? ? ?   |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---  |  | 17. INFORMANT<br>Baltimore, Md. 21224<br>Joseph A. Hock - 32 N. Lakewood Ave.   |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Bronchopneumonia<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>Dementia   |  |   |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 5, 1986, to March 19, 1986, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 19, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>3/19/86   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dorothy Lawton MD   |  |   | 22e. ADDRESS<br>9000 Franklin Square Drive   |   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>3/22/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem.                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John A. Moran, Inc. Funeral Home   |  |   | 25. DATE REC'D. BY REGISTRAR<br>MAR 24 1986  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                  |   |  |  |  |
| 3000 E. Baltimore St., Balto., Md. 21224   |  |   |  |   |  |   |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is moved to item 18, check any injury, or other traumatic event, immediately following the death.

20% COTTON



2000 E. Baltimore St. Baltimore, Md. 21224  
John F. Morris, Inc. Funeral Home  
Baltimore, Md. 21206

No. 100-10-6700-10000  
Jacob P. Morris  
Baltimore, Md. 21224  
No. 100-10-6700-10000  
Jacob P. Morris  
Baltimore, Md. 21224  
No. 100-10-6700-10000  
Jacob P. Morris  
Baltimore, Md. 21224  
No. 100-10-6700-10000  
Jacob P. Morris  
Baltimore, Md. 21224

00-01613

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |  |
|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Edward J. Hogan   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 26 86 |   |   | 2b. HOUR<br>6:05 a.m.  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 26 14   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Youngstown Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Martin's Home for the Aged                        |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Priest |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Religious   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. Balto. Catonsville |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br>21228 601 Maiden Choice Lane                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bernard J. Hogan   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Mc Mahon   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>364-48-6875   |  | 17. INFORMANT ADDRESS<br>Sr. Mary Augustine 601 Maiden Choice Lane  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC COLON CA.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 21g. I certify that (1) this hospital attended the deceased from <u>SEPT 12 1979</u> to <u>MARCH 26 1986</u> that (1) (we) lost (a) (we) did not see the body after death  |  |  |  |   |   |  |  |
| 22a. SIGNATURE<br><i>Dianna H. Corbett</i>   |  |  |  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>3/26/86  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DIANNA H. CORBETT   |  |  |  | 22d. ADDRESS<br>900 CATON AVE. BALT. MD 21229   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Mar. 29, 1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sulpician   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto. Md.       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Leonard J. Ruck Inc. Baltimore, Maryland   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1986  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>                |  |

STATE OF MICHIGAN  
DEPARTMENT OF STATE  
DIVISION OF RECORDS

County of ...  
City of ...  
State of Michigan

Recorded in ...  
Book ...  
Page ...  
Date ...

065104

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 5 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |   |   |
|--|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Jean Marie Hollar</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 1, 1986</b>                      |   | 2b. HOUR<br><b>4:08p</b> M                      |   |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 6 1933</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>             |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Paul P. Gurecki</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna H. Zavistowski</b>      |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>210-26-0534</b> |   | 17. INFORMANT ADDRESS<br><b>Emery E. Hollar</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastatic Breast Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: _____ |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 4, 1986</b> , to <b>March 1, 1986</b> , that (I) (we) last saw the deceased alive on <b>March 1, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |
| 22b. SIGNATURE<br><i>[Signature]</i> MD.   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>3/1/86</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Douglas R Lawlor MD</b>  |  |  |   | 22e. ADDRESS<br><b>2000 Franklin Square Doris</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/5/1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |
| 24. FUNERAL DIRECTOR NAME<br><b>Duda-Ruck, Inc.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |
| 7922 Wise Avenue Dundalk, Maryland 21222   |  |  |   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use on the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

RECEIVED  
 10/10/50  
 10/10/50

00-02248

FOR Item 5,13d, Fill out  
STATE  
REGISTRATION 1/20/90 It.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 7 6 0

REG. NO.

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CARROLL</b>                                   |  | FIRST<br><b>H.</b>  |  | MIDDLE<br><b>HOLLINGSHEAD</b>   |  | LAST<br><b>MAR. 24, 1986</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  | 2b. HOUR<br><b>6 A.M.</b>                            |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 24, 1986</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                        |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Painting</b> |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br><b>NO</b>                                   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Phoenix</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1805 Maryland Ave. 21131</b>       |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Isaac Hollingshead</b>                     |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Hitchcock</b> |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII</b>  |  | 17. INFORMANT ADDRESS<br><b>Maude Hollingshead 1805 Maryland Ave. Phoenix, MD 21131</b>   |  |   |  |  |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Endotracheal Bleeding. 2<sup>nd</sup> to 3<sup>rd</sup> DIC.</b>  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Infarction Pulmonary Bronchitis COPD.</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a                     |  |   |  |

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Kamal</b>  |  |   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |   |  |

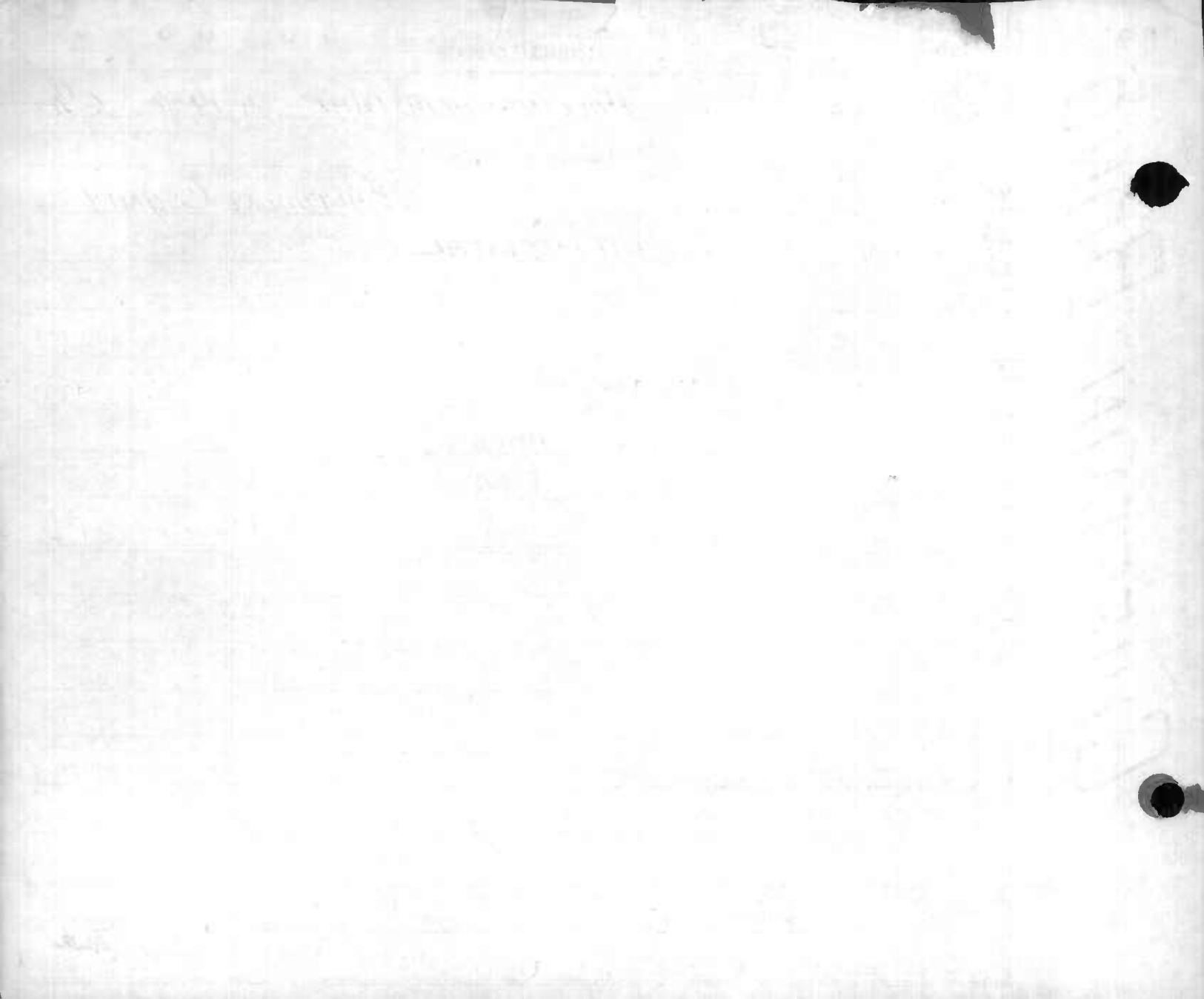
|   |  |                                    |  |  |  |  |  |
|---|--|------------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>March 27, 1986</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hereford Baptist Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hereford, Baltimore, MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.J. Hartenstein</b>       |  |                                    |  | ADDRESS<br><b>Second at Franklin St. New Freedom, PA 17349</b>         |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 31 1986</b>                          |  |
|   |  |                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>K. Davidson</b>                       |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified at once.







00-00200

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 6 1

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX  |  | 4. RACE  |  |
| Edna K. Walzer   |  | F   |  | W  |  |
| 5. BIRTHPLACE (COUNTRY)  |  | 6. CITIZEN OF WHAT COUNTRY?   |  | 7. DATE OF BIRTH MONTH DAY YEAR  |  |
| WASH., D.C.  |  | U.S.  |  | 3/19/97  |  |
| 8. CITY OR TOWN OF DEATH   |  | 9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 10. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Touson   |  | Pickersgill   |  | Balt Co  |  |
| 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 12. USUAL OCCUPATION (IF NOT WORKING, GIVE MOST OF WORKING LIFE)                                      |  | 13. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| Md   |  | Balt  |  | Baltimore  |  |
| 14. FATHER'S NAME (TYPE OR PRINT)  |  | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)  |  | 16. SOCIAL SECURITY NO.  |  |
| Frederick A. Walzer  |  | Anna M. Zinnell   |  | 212-03-0573  |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 18. INFORMANT   |  | ADDRESS  |  |
| no   |  |   |  |  |  |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| Cardiac Arrest   |  |   |  | 2 Hour   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |
|  |  |   |  | Arteriosclerosis   |  |
|  |  |   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |
|  |  |   |  | 25 year  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |
| Neuropathy in legs. Unknown Etiology   |  |   |  |  |  |
| 20a. DATE OF OPERATION   |  | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20c. AUTOPSY?  |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERWAY? <input type="checkbox"/> OR CONTRIBUTING? <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | P.M. 19   |  |  |  |
| 22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                   |  | 22c. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |   |  |  |  |
| 23. I certify that (I) (the hospital) attended the deceased from June 19 82 to March 2 19 86 that (I) last saw the deceased alive on Jan 30 19 86 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |   |  |  |  |
| 24. SIGNATURE  |  | DEGREE  |  | 25. DATE SIGNED  |  |
| Keith A. Manley  |  | MD  |  | 3.2.86   |  |
| 26. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 27. ADDRESS   |  | 28. DATE REC'D. BY REGISTRAR   |  |
| KEITH A. MANLEY  |  | 6151 CHESTNUT AVENUE<br>TOUON - MD 21204  |  | MAR 11 1986  |  |
| 29. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 30. DATE  |  | 31. NAME OF CEMETERY OR CREMATORY  |  |
| Removal  |  | 3/2/86  |  | BALTO., MD.  |  |
| 32. FUNERAL DIRECTOR (NAME)  |  | 33. ADDRESS   |  | 34. DATE REC'D. BY REGISTRAR   |  |
| Anatomy Board  |  | Balto., Md.   |  | MAR 11 1986  |  |
| 35. REGISTRAR'S SIGNATURE  |  | 36. REGISTRAR'S SIGNATURE   |  | 37. REGISTRAR'S SIGNATURE  |  |
|  |  |   |  |  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, a necessary injury or other traumatic event, the medical examiner must be notified at once.

DANDY

20% COTTON FIBRE

MADE IN  
ENGLAND



00-00275

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8606962

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |                         |  |   |  |  |  |   |   |  |  |
|---|--|-------------------------|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Michael W. Holzheid</b>  |  |                         | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>13</b> YEAR <b>86</b>   |   |  | 2b. HOUR<br><b>7:58</b> M  |  |   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>26</b> YEAR <b>09</b> |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |   | 8. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         | 9b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.        |  |  |
| 12. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |                         | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |   |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired- Printer</b>   |  |   | 15. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Eastpoint</b>  |  |                         |  |   |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   | 18. STREET ADDRESS / ZIP CODE<br><b>7707 Wynbrook Road 21224</b>            |  |  |
| 19. FATHER'S NAME<br>FIRST <b>John</b> MIDDLE <b>Holzheid</b> LAST <b>Holzheid</b>  |  |                         |  |   |  | 20. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>Weller</b> LAST <b>Weller</b>  |  |   |   |  |  |
| 21a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  |                         | 21b. SOCIAL SECURITY NO.<br><b>WW11 212-05-7135</b>  |   |  | 22. INFORMANT<br>ADDRESS<br><b>James A. Haynie 329 South Newkirk St. 21224</b>   |  |   |   |  |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastric cancer with metastatic disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |                         |  |   |  |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |
| 24a. DATE OF OPERATION  |  |                         | 24b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 25a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 25b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                         | 26b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   |  | 26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |  |  |
| 27a. INJURY OCCURRED<br>WHERE <input type="checkbox"/> HOT WHERE <input type="checkbox"/><br>AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         | 27b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)   |   |  | 27c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |
| 28. I certify that (1) this hospital attended the deceased from <b>3/8</b> to <b>3/13</b> 19 <b>86</b> , that (2) I saw the deceased alive on <b>3/13</b> 19 <b>86</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If not, add (did not) view the body after death)   |  |                         |  |   |  |  |  |   |   |  |  |
| 29a. SIGNATURE<br><b>Maxhuda</b>  |  |                         |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                    |  |   | 29b. DATE SIGNED  |  |  |
| 30a. PHYSICIAN'S HOME (TYPE OR PRINT)   |  |                         |  |   |  | 30b. ADDRESS   |  |   |   |  |  |
| 31a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |                         | 31b. DATE<br><b>3/17/86</b>  |   |  | 31c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b>   |  |   | 31d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE |  |  |
| 32. FUNERAL DIRECTOR<br>NAME<br><b>Connolly Funeral Home of Dundalk</b>   |  |                         |  |   |  | 33a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>  |  |   | 33b. REGISTRAR'S SIGNATURE<br><b>in Jackson-Randall</b>                     |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-01800

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8606963

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ARTHUR MICHAEL HOMER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 24 '86</b>                                    |   | 2b. HOUR<br><b>11:45A</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 8, 1942</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>43</b><br>YRS MONTHS DAYS                             |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Bel Air, Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Master Mechanic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Heavy Equipment</b>  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Harford</b>  |   | 13c. CITY OR TOWN<br><b>Bel Air</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur James Homer</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Juanita -- Durman</b>                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Vietnam 218-38-4850</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Victoria I. Homer, 228 Crocker Drive, Bel Air, Md. 21014</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>METASTATIC COLON CANCER</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/19</b> , 19 <b>86</b> , to <b>3/24</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/24</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Michael Sipple</i>   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/24/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL SIPPLE, M.D.</b>  |  | 22e. ADDRESS<br><b>GBMC - 6701 N. CHARLES STREET 21204</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Mar. 27, 1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial Gardens, Bel Air Harford Md.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Howard K. McComas III, Abingdon, Md. 21009</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 31 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John A. Davidson</i>                                       |  |

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial/transfer permit. Then please remove carbon copies: Pages 1 and 2 (including this one) within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked "AT WORK", the medical examiner must be notified.

WILFRED DUND

2009-01-03-002

00-01643

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|---|--|--|-----------------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE KNOWN OF DEATH  |  |  | 2b. DATE ESTIMATED  |  |  | 2c. DATE PRONOUNCED DEAD    |  |  | 2d. HOUR   |  |  |
| Mary Elizabeth Horn  |  |  |   |  |  | 3. SEX   |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH            |  |  | 6. AGE (IN YEARS)  |  |  |
| Female   |  |  | Caucasian   |  |  | March 15, 1908   |  |  | 78 YRS.   |  |  |                             |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |                             |  |  |  |  |  |
| Pennsylvania   |  |  | United States   |  |  |  |  |  | Baltimore County  |  |  |                             |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |                             |  |  |  |  |  |
| Woodlawn   |  |  | 1920 Gwynn Oak Avenue 21207   |  |  | Homemaker  |  |  |   |  |  |                             |  |  |  |  |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS         |  |  |  |  |  |
| Maryland   |  |  | Baltimore   |  |  | Woodlawn   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 1920 Gwynn Oak Avenue 21207 |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
| Matthew  |  |  | Scott   |  |  | Elizabeth  |  |  | Jaynes  |  |  |                             |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT  |  |  | ADDRESS   |  |  |                             |  |  |  |  |  |
| No   |  |  | 215-54-4632   |  |  | George L. Horn   |  |  | 1920 Gwynn Oak Avenue   |  |  | 21207                       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A.S.C.V.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |   |  |  |  |  |  |   |  |  |                             |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 years</u> |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |  |   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
|  |  |  |   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
| 20. AUTOPSY?   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |   |  |  |                             |  |  |  |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
|  |  |  | P.M. 19   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  | 21f. LOCATION  |  |  |   |  |  |                             |  |  |  |  |  |
|  |  |  |   |  |  | CITY OR TOWN COUNTY STATE  |  |  |   |  |  |                             |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
| ACTUAL SIGNATURE   |  |  | M.D.  |  |  | MEDICAL EXAMINER   |  |  | DATE SIGNED   |  |  |                             |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  | ADDRESS   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
| E-P. WILLIAMSON  |  |  |   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |  |                             |  |  |  |  |  |
| Burial   |  |  | March 24, 1986  |  |  | Lorraine Park  |  |  | Woodlawn Baltimore Maryland   |  |  |                             |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |  |                             |  |  |  |  |  |
| Loring Byers Funeral Directors, INC.   |  |  | MAR 27 1986   |  |  | John Davidson-Randall  |  |  |   |  |  |                             |  |  |  |  |  |
| 8728 Liberty Road Randallstown, MD 21133-4784  |  |  |   |  |  |  |  |  |   |  |  |                             |  |  |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82







00-01978

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8606965

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GOLDIE</b>  |  | FIRST<br><b>HORNSTEIN</b>   |  | LAST   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 29 86</b>  |  | 2b. HOUR<br><b>0414AM</b>   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 19 26</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>               |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6867 PARSONS AVE. #21207</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>BERNARD JACOBSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>IDA MARCUS</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-50-2219</b>   |  | 17 INFORMANT<br><b>MRS. BERNICE PAPER</b><br><b>6867 PARSONS AVE. BALTO., MD 21207</b>   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Brain generalized bleeding</b> |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>C.H.F. Pneumonia</b>  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Hadeez A. Syed</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br><b>3/29/86</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. A. SYED MD</b>   |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN HOSP.</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>MAR. 30, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD FREE STATE POST 167 J.W. ROSEDALE</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Sol Levinson</b>  |  |   |  |

MEDICAL CERTIFICATION

991X

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

95P10-00



00-02144

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                                    |   |   |   |   |  |
|--|--|--|--|---|------------------------------------|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Hazel Dolores Hoshall</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 29, 1986</b>           |   |                                    | 2b. HOUR<br><b>7:15 P.M.</b>  |   |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 24, 1906</b>   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>79</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                       |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Ruxton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1205 Robin Hood Circle</b> |  |   |                                    | 12a. USUAL OCCUPATION<br>(IF NOT WORKING, GIVE MOST OF WORKING LIFE)<br><b>Home Maker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Ruxton</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1205 Robin Hood Circle 21204</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Ponkow</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella J Sweeney</b> |   |                                    |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-74-2030</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Miss Ann Marie Welsh</b>   |                                    |   | Same As 13e   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Fibrillation</b> |  |  |  |   |                                    |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2d.</b><br><b>2mo.</b><br><b>12mo.</b>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>none</b>   |  |  |  |   |                                    |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>---</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>   |  |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>---</b>   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7:30 P.M. 1986</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>---</b>  |                                    |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>---</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>---</b>   |                                    |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 27, 1986</b> to <b>29 Mar 1986</b> , that (I) (we) last saw the deceased alive on <b>27 Mar 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not attend the body after death, the body after death, <b>---</b> )                           |  |  |  |   |                                    |   |   |   |   |  |
| 22b. SIGNATURE<br><b>George J. Richards</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |                                    |   |   | 22c. DATE SIGNED<br><b>4/1/86</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George J Richards M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>7800 York Rd Towson, Maryland</b>  |                                    |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>4/2/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |                                    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                  |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 02 1986</b>   |                                    | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                |   |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director and within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP



00-00493

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

86 06967

FOR  
STATE  
REGISTRAR

## CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |  |   |  |  |  |  |
|---|--|--|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LILLIE M. HOWARD</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 14 86</b>                        |   | 2b. HOUR<br><b>19:30 M</b>                                    |  |   |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 - 17 - 09</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. Gen. Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Owings Mills</b>                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>116 Wengate Rd. 21117</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Enos Thompson</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Rebecca Young</b> |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>No</b>     |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-74-8558</b> |  |
| 17. INFORMANT<br>ADDRESS<br><b>Owings Mills 21117</b>   |  |  | 17. INFORMANT<br>NAME<br><b>Mrs. Dorothy Pulliam</b>                         |   |   | 17. INFORMANT<br>ADDRESS<br><b>116 Wengate Rd.</b>                                   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA VS. MI.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>COPD; IDDM; CHF; Pleural effusion; Suspected CA hyp.</b>   |  |  |  |   |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>            |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)        |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-17-86</b> to <b>3-17-86</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-14-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>PETER O'DRISCOLL</b>   |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |   |   | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   | 22c. DATE SIGNED<br><b>3-14-86</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER O'DRISCOLL</b>  |  |  | 22e. ADDRESS<br><b>1777 RANDALLSTOWN RD., 21208</b>                          |   |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>3-17-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Jessops Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Balto. Md.</b>                    |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bryan W. Clary</b>   |  |  | ADDRESS<br><b>10 W. Padonia Rd. 21093</b>                                    |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 17 1986</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

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00-004815

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 06968

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH A HUBBARD</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>14</b> YEAR <b>86</b>  |  | 2b. HOUR<br><b>9 P. M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>Nov</b> DAY <b>23</b> YEAR <b>1899</b>                  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. Gen. Hosp.</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Reisterstown</b> |  |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>234 Tidyman Rd. 21136</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Terry H.</b> MIDDLE <b>Bryan</b> LAST <b>Bryan</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Julia</b> MIDDLE <b>M.</b> LAST <b>Giles</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-68-8694</b>  |  | 17. INFORMANT<br>ADDRESS <b>234 Tidyman Rd. Reisterstown Md.</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Ca Pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>—</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                            |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3.11.19.86</b> to <b>3.14.19.86</b> , that (I) (we) last saw the deceased alive on <b>3.14.19.86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Rayadorg Govinda Rao</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3.14.86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYADORG GOVINDA RAO MD</b>   |  | 22e. ADDRESS<br><b>BALT COUNTY GENL HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Mar. 17, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Mem. Gar.</b>                     |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Finksburg Carroll Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME <b>H. J. Schmitt</b> ADDRESS <b>Owings Mills, Md</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 17 1986</b>                                  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>H. J. Schmitt</b>  |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remain the property of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

BP





066197

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 06969

REG. NO. 1

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |  |   |  |  |  |
|--|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SAMUEL J. HUBBARD, III</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 04 '86</b>                       |   |   | 2b. HOUR<br><b>12:55A</b>  |   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 21 '44</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Designer</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Western Elec.</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Jarrettsville</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1665 Dulaney Dr., 21084</b>         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Jeremiah Hubbard, III</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth Ellen Bayne</b>     |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>220-40-9635</b>   |  |  | 17. INFORMANT<br>ADDRESS<br><b>Carol L. Hubbard, 1665 Dulaney Dr., 21084</b> |   |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>SUBARACHNOID BLEED FROM RIGHT COMMUNICATING ARTERY ANEURYSM -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/5/86</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>3/5/86</b>            |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>            |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/5/86</b> to <b>3/04/86</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/04/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>S. FERESHETIAN, M.D.</b>  |  |  | DEGREE<br><b>M.D.</b>  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>3/4/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SIRATHE FERESHETIAN M.D.</b>   |  |  | 22e. ADDRESS<br><b>GREATER BALTIMORE MEDICAL CENTER</b>                      |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/5/86</b>   |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cem.</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium Balto. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>J. E. Lowell Lemmon</b>   |  |  | ADDRESS<br><b>10 W. Padonia Rd.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 5 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. E. Lowell Lemmon</b>   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |                 |  |  |       |
|--|--|--|--|---|--|--|--|-----------------|--|--|-------|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  | REG. NO. 1   |  |                 |  |  |       |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | March 28, 1986  |  | 10:15 am   |       |
| JOHN   |  | B.   |  | HUMPHREY  |  |  |  |                 |  |  |       |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                              |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS  |       |
| Male   |  | Caucasian  |  | Jan. 6, 1947  |  | 39   |  | MONTHS          |  | DAYS   |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |                 |  |  |       |
| Maryland   |  | USA  |  |   |  | Baltimore County   |  |                 |  | MD.  |       |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |                 |  |  |       |
| Towson   |  | Greater Baltimore Medical Center   |  | Attendant   |  | Gas Station  |  |                 |  |  |       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS / ZIP CODE                                 |  |                 |  |  |       |
| Maryland   |  | Balto  |  | <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 3215 Pelham Ave, 21213   |  |                 |  |  |       |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |                 |  |  |       |
| John   |  | Marian   |  | Hamby   |  |  |  |                 |  |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |                 |  |  |       |
| No   |  | 213-52-8177  |  | Laurali L. Humphrey, Wife, same as  |  |  |  |                 |  |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |                 |  |  |       |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |       |
| IMMEDIATE CAUSE (a) Encephalitis, probably viral   |  |  |  |   |  |  |  |                 |  | above one month  |       |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |                 |  |  |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |  |   |  |  |  |                 |  |  |       |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |                 |  |  |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                   |  |  |  |   |  |  |  |                 |  |  |       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                 |  |  |       |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                 |  |  |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |                 |  |  |       |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |                 |  |  |       |
|  |  | P.M. 19  |  |   |  |  |  |                 |  |  |       |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  | CITY OR TOWN   |  | COUNTY          |  | STATE  |       |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET  |  |  |  |                 |  |  |       |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/2 86 to 3/28 86, that (I) (we) lost   |  |  |  |   |  |  |  |                 |  |  |       |
| saw the deceased alive on 3/28 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated                   |  |  |  |   |  |  |  |                 |  |  |       |
| 22b. SIGNATURE   |  |  |  |   |  |  |  |                 |  | DEGREE   |       |
| John E. Adams, M.D.  |  |  |  |   |  |  |  |                 |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |       |
| 22c. DATE SIGNED   |  |  |  |   |  |  |  |                 |  | 3/28/86  |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   |  |  |  |                 |  | 22e. ADDRESS   |       |
| John E. Adams, M.D.  |  |  |  |   |  |  |  |                 |  | 6701 N. Charles St. Baltimore MD 21204   |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  | CITY OR TOWN    |  | COUNTY   | STATE |
| Cremation  |  | 3/31/86  |  | Greenmount Crematory  |  | Balto, Md.   |  |                 |  |  |       |
| 24. FUNERAL DIRECTOR   |  | 3331 Brehms Lane   |  | DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |                 |  |  |       |
| NAME   |  | ADDRESS  |  | APR 01 1986   |  |  |  |                 |  |  |       |
| SCHIMUNEK FUNERAL HOME, Balto, Md. 21213   |  |  |  |   |  |  |  |                 |  |  |       |

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remember to mail pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or item 21 shows any injury, or other traumatic event, the medical examiner must be notified.

**MEDICAL CERTIFICATION**

|  |  |   |  |   |  |   |  |  |  |                                    |  |                    |  |
|--|--|---|--|---|--|---|--|--|--|------------------------------------|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Edward   |  | MIDDLE<br>William   |  | LAST<br>Huneke  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  | March 17 1986                      |  | 2b. HOUR<br>7:15pm |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 27 1902  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.  |  |                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |                                    |  |                    |  |
| 10. CITY OR TOWN OF DEATH<br>Chase   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>13108 Cherwin Road |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired-Balto. City Police  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |                                    |  |                    |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Chase  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>13108 Cherwin Road 21220   |  |                                    |  |                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles William Huneke   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Augusta Sche                                   |  |  |  |                                    |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-30-7509  |  | 17. INFORMANT ADDRESS<br>Mary Huneke 13108 Cherwin Road 21220                                   |  |  |  |                                    |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Melanin</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u> |  |   |  |   |  |   |  |  |  |                                    |  |                    |  |
| MEDICAL CERTIFICATION  |  |   |  |   |  |   |  |  |  |                                    |  |                    |  |
| 19a. DATE OF OPERATION<br><u>11/15</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                    |  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |                                    |  |                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                                    |  |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>month</u> , 19 <u>80</u> , to <u>month</u> , 19 <u>1986</u> , that (I) (we) lost<br>saw the deceased alive on <u>3-13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |                                    |  |                    |  |
| 22b. SIGNATURE<br><u>Louis C Broschi</u> DEGREE <u>MD</u>  |  |   |  |   |  |   |  |  |  | 22c. DATE SIGNED<br><u>3/20/88</u> |  |                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Louis C Broschi</u>  |  |   |  |   |  | 22e. ADDRESS<br><u>9101 Franklin Square Dr - 21223</u>  |  |  |  |                                    |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/21/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cemetery   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Middle River Balto. Maryland   |  |                                    |  |                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Connelly Funeral Home 300 Mace Ave. 21221  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 24 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>   |  |                                    |  |                    |  |

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*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. Some fragments are visible, such as "The following information", "is being furnished", and "to the Bureau of the Census".]*

00-01640

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 9 7 2

REG. NO.

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Harry Raymond Huneke  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>March 22 1986  |  | 2b HOUR<br>M  |
| 3 SEX<br>Male   | 4 RACE<br>White  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>August 15 1923  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                              |   |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 9b CITIZEN OF WHAT COUNTRY?<br>Usa   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |
| 10 CITY OR TOWN OF DEATH<br>Chase   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>12540 Ulrich Ave. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     | 12b KIND OF BUSINESS OR INDUSTRY   |   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE Md. 13b COUNTY Balto. 13c CITY OR TOWN Chase   |  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE<br>12540 Ulrich Ave. 21027                 |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Huneke   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Augusta Schene                                 |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  | 16b SOCIAL SECURITY NO.<br>WW11 219-18-5830  | 17 INFORMANT ADDRESS<br>Ethel Huneke 12540 Ulrich Ave. 21027   |  |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>Coronary Pulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE (b) <i>Cor Pulmonale</i><br>DUE TO, OR AS A CONSEQUENCE (c) <i>Chronic Obstructive Pulmonary Disease</i>  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION GIVEN IN PART 1<br><i>Arteriosclerosis / Poor Nutrition with Chronic Congestive Failure</i>   |  |  |  |  |   |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2)   |  |  |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a I certify that (I) (this hospital) attended the deceased from <i>2-18</i> 19 <i>86</i> to <i>2-18</i> 19 <i>86</i> that (I) (we) last saw the deceased alive on <i>2-18</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (and) not view the body after death. |  |  |  |  |   |
| 22b SIGNATURE<br><i>Dr. Yosucio</i>   |  | DEGREE<br><i>M.D.</i>  |  | 22c DATE SIGNED<br><i>3/29/86</i>  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Yosucio   |  | 22e ADDRESS  |  |  |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  | 23b DATE<br>3/25/86  | 23c NAME OF CEMETERY OR CREMATORY<br>BelAir Memorial   | 23d LOCATION<br>BelAir Harford Maryland  |  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Connelly Funeral Home 300 Mace Ave. 21221  |  | 25a DATE RECEIVED BY REGISTRAR<br>MAR 27 1986  |  | 25b REGISTRAR'S SIGNATURE<br><i>Jane Davidson</i>                        |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



RECEIVED

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00-02118

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 1 0 6 9 7 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>FIRST MIDDLE LAST<br>Clara Constance HUNT   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 28, 1986 |   | 2b. HOUR<br>p<br>9:00 M  |  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Cauc.   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11/26/01  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>85 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Dallas, Texas   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hosp. |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Spears  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Karen Stotts  |   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No - |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>453-38-4891   |  | 17. INFORMANT<br>June Mendelson, 11 Garrison Rd.   |   |   |  | 18. STREET ADDRESS / ZIP CODE<br>2126 Red Thorn Rd. 21220  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of the lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/11, 19 86, to 3/28, 19 86, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/28, 19 86, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Albert K Lee M.D.   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>3.28.85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Albert K. Lee, M.D.  |  |  |   | 22e. ADDRESS<br>9000 Franklin Sq. Dr., Balto., 21237  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Entombment  |  | 23b. DATE<br>4/3/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Mausoleum  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Schimmek Funeral Home, Inc.<br>3331 Brehms Lane, Balto., Md. 21213  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 01 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>John Anderson-Randall  |  |  |  |

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SARAH ATWELL HUTSON</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 27, 1986</b>   |  | 2b. HOUR<br><b>4:30A M</b>   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 27, 1895</b>                        |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian-Multi Medical</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>     |  |  |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>610 Hatherleigh Road 21212</b>  |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Atwell</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-58-3831</b>   |  | 17. INFORMANT ADDRESS<br><b>Ruth Graw 720 Overbrook Road 21212</b>                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO pul arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CA - Ovary</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerotic Cardiovascular Disease</b> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MIN</b><br><b>months</b><br><b>yrs</b> |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (the hospital) attended the deceased from <b>June 5, 1986</b> to <b>March 27, 1986</b> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Sidney J. Venable</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>3-28-86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sidney J. Venable</b>  |  | 22e. ADDRESS<br><b>7215 York Road 21204</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b>  |  | 23b. DATE<br><b>3-29-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mountainview Cemetery</b>                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Howard Maryland</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>  |  |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |   |

MEDICAL CERTIFICATION

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.



066198

1- FOR  
STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 7 5

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LOUISE Anna HYNSON   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 3 86                                |  | 2b. HOUR<br>4:15a M                             |
| 3. SEX<br>FEMALE  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 14 19   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Restaurant |
| 13a. STATE<br>Maryland  |   |   | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Cockeysville  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Baublitz   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Tillman  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |  | 17. INFORMANT<br>ADDRESS<br>Arthur R. Knox, 300 Lord Byron Lane, 21030               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | 21030<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u>   |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/25 19 86</u> , to <u>3/3 19 86</u> , that (I) (we) last saw the deceased alive on <u>3/3 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |  |   |
| 22b. SIGNATURE<br><i>Rudiger Breiteneker</i><br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   |   |  | 22c. DATE SIGNED<br>3/4/86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rudiger Breiteneker, M.D.  |   |   |  | 22e. ADDRESS<br>6701 N. Charles Street 21204   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |   | 23b. DATE<br>3/6/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. James Ch. Cem.                             |   |
| 23d. LOCATION<br>CITY OR TOWN<br>Monkton  |   | 23e. COUNTY<br>Balto.   |  | 23f. STATE<br>Md.  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson, 10 W. Padonia Rd.   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1986  |   |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Swinden</i>                                   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WILKINSON



Handwritten signature or initials.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 6 9 7 6

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Norma Irene Iampieri   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/6/86   |  |  |  | 2b. HOUR<br>11:50 P.M.  |  |
| 3. SEX<br>F   |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 15 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>—  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>437 Whitfield Rd. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retiree  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>437 Whitfield Rd. 21229   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Williams  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Beckerberg  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-38-8840   |  | 17. INFORMANT<br>NAME ADDRESS<br>Norma Iampieri 437 Whitfield Rd.   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Cardiovascular Arrest   |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Immediate |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) Advanced Endometrial Cancer 2 <sup>nd</sup> Metastases  |  |  |  |   |  |  |  |   | 1 mo   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) Breast Cancer   |  |  |  |   |  |  |  |   | 9 yrs  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/6 19 86 to 3/6 19 86, that (I) (we) last saw the deceased alive on 2/7 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>William C. Waterfield   |  |  | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input checked="" type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/7/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William C. Waterfield MD   |  |  | 22e. ADDRESS<br>St Agnes Hospital<br>900 Caton Ave Balt Md 21229       |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>3/10/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Fountain Park Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore County Md. |   |  |
| 24. FUNERAL DIRECTOR<br>Charles L. Nelson   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>11 1986                               |   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |   |  |

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 06977

REG. NO.

|  |  |                           |   |   |  |  |  |  |  |  |  |
|--|--|---------------------------|---|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ILLSTON, HARRY</b>   |  |                           | 7a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>2</b> YEAR <b>86</b>   |   |  | 7b. HOUR <b>11</b> AM  |  |  |  |  |  |
| 3. SEX<br><b>M Male</b>  |  | 4. RACE<br><b>White W</b> |   | 5. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>22</b> YEAR <b>22</b> |  | 6. AGE - (IN YEARS LAST BIRTHDAY)<br><b>64</b>   |  | 8. UNDER 1 YEAR<br>MONTH <b>1</b> DAY <b>1</b> HOUR <b>1</b> |  |  |  |
| 7c. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>ENGLAND</b>   |  |                           | 7d. CITIZEN OF WHAT COUNTRY?<br><b>England</b>  |   |  | 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/> |  |  | 1. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt. County</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  |                           | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)<br><b>ST. Joseph Hosp.</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF BUSINESS)<br><b>AUTO MECHANIC</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AUTO BODY</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>   |  |                           | 13b. COUNTY <b>Baltimore</b>  |   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>906 Revery Rd. 21212</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>Robert</b> LAST <b>Illston</b>   |  |                           | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Margaret</b> MIDDLE <b>Hanlon</b> LAST <b>Hanlon</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>817-74-6133</b>   |  |  |
| 17. INFORMANT<br><b>Mrs. Mary F. Illston</b>   |  |                           | 17a. ADDRESS<br><b>906 Revery Road 21212</b>  |   |  | 17b. PHONE NO.<br><b>XXXXXXXXXX</b>  |  |  | 17c. RELATIONSHIP TO DECEASED<br><b>WIFE</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPOTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PERFORATED DUODENAL ULCER &amp; PERITONITIS</b> |  |                           |   |   |  |  |  |  | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)   |  |                           |   |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/2/86</b>  |  |                           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Internal Bleeding</b>  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                           | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                           | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |                           |   |   |  |  |  |  |  |  |  |
| 23a. SIGNATURE<br><b>James V. Deegan</b>   |  |                           |   |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |  |  | 23b. DATE SIGNED   |  |  |
| 24. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JACINTO V-DE BOERIN</b>   |  |                           |   |   |  | 24a. ADDRESS<br><b>St. Joseph's Hospital</b>   |  |  |  |  |  |
| 25a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Cremation</b>  |  |                           | 25b. DATE<br><b>3-3-86</b>  |   |  | 25c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>  |  |  | 25d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City Maryland</b>   |  |  |
| 26. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home</b>   |  |                           |   |   |  | ADDRESS<br><b>6500 York Road 21212</b>   |  |  | 27a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1986</b>   |  |  |
|  |  |                           |   |   |  | 27b. REGISTRAR'S SIGNATURE<br><b>John W. Davidson</b>  |  |  |  |  |  |

MEDICAL CERTIFICATION

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

RECEIVED

DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

OFFICE OF THE ATTORNEY GENERAL

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

00-01527

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remember to return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8606978   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>NETTIE R JACOBSON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>23</b> YEAR <b>86</b> |   |  | 2b. HOUR<br><b>7<sup>18</sup> AM</b>   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>29</b> YEAR <b>07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS <b>78</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. County Gen. Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assistant</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beauty Shop</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Reisterstown</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>O.</b> LAST <b>Cockey</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Harriett</b> MIDDLE <b></b> LAST <b></b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>109T2 Glyndon Dr. 21136</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-20-8470</b>  |  | 17. INFORMANT <b>14129</b> ADDRESS <b>Old Hanover Rd.</b><br><b>Ms. Barbra Sullivan Reisterstown, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>MYOCARDIAL INFARCTION.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>a</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-15-19-86</b> to <b>3-23-19-86</b> , that (I) (we) lost <b>saw the deceased alive on 3-23-19-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. R. Depestre</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3-23-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. DEPESTRE</b>  |  |   |  | 22e. ADDRESS<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>3-23-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>27 MAR 1986</b>   |  |  |  |
| ADDRESS<br><b>Balto., Md.</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John D. ...</b>  |  |  |  |



00-01798

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 06979

REG. NO.

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Robert M Jackson   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>March 23 1986  |  | 2b HOUR<br>M  |
| 3 SEX<br>Male  | 4 RACE<br>Black  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 5 22  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                                      | IF UNDER 1 YEAR<br>MONTHS DAYS  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md   | 7b CITIZEN OF WHAT COUNTRY?<br>USA   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |   |
| 10 CITY OR TOWN OF DEATH<br>Towson   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. Joseph Hospital |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Postal U.S. Service   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br>MD.  |  | 13c CITY OR TOWN<br>Baltimore   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE<br>712 Mount Holly St. 21229                     |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert H. Jackson, Sr   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Anderson   |  |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Korean 219-10-9881  |  | 17 INFORMANT ADDRESS<br>Gladys I. Jackson 712 Mt Holly Street                  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cancer gets and can't</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____               |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 mos  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Pulmonary edema death</u>  |  |   |  |  |   |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>86</u> , to <u>Mar</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>Mar 19</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><u>Arthur A. Seppick</u>   |  | DEGREE<br><u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>3/24/86</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Arthur A. Seppick</u>  |  | 22e. ADDRESS<br><u>St. Joseph Hosp</u>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/29/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                         |   |
| 23d. LOCATION<br>(CITY OR TOWN)<br>Arbutus, Md.  |  | COUNTY  |  | STATE  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H West   |  | ADDRESS<br>4300 Washab Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1986                                   |   |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Gelia Davidson-Randall</u>                    |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hour of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers, pages 1 and 2, and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, early injury, or other traumatic event, the medical examiner will be notified.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 6 7 8 0

REG. NO.

|  |   |  |   |  |   |   |   |   |
|--|---|--|---|--|---|---|---|---|
| FOR<br>STATE<br>REGISTRAR  |   | 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST<br><i>EVA</i>  | MIDDLE<br><i>MAE</i>  | LAST<br><i>Jenkins</i>  | 2a. DATE OF DEATH<br>MONTH<br><i>3</i> DAY<br><i>25</i> YEAR<br><i>86</i>   | 2b. HOUR<br><i>6:50 PM</i>                          |
| 3. SEX<br><i>F</i>   | 4. RACE<br><i>B</i>                           | 5. DATE OF BIRTH<br>MONTH<br><i>2</i> DAY<br><i>15</i> YEAR<br><i>22</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>63</i> YRS   |   | IF UNDER 1 YEAR<br>MONTHS<br><i></i> DAYS<br><i></i>                                |   | IF UNDER 24 HRS<br>HOURS<br><i></i> MIN.<br><i></i> |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.       |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Stella Maris Hospice</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>IBM.</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |
| 13a. STATE<br><i>MARYLAND</i>  |   | 13b. COUNTY<br><i>BALTO</i>  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS / ZIP CODE<br><i>4 WATER WAY COURT APT. 2A 21204</i>  |   |   |   |
| 14. FATHER'S NAME<br>FIRST<br><i>RUFORD</i> MIDDLE<br><i></i> LAST<br><i>ALLEN</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><i>LOUISE</i> MIDDLE<br><i></i> LAST<br><i>FASION</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |   |   |   |   |
| 16b. SOCIAL SECURITY NO.<br><i>237-20-5010</i>   |   | 17. INFORMANT<br><i>WILLIAM H. JENKINS</i>   |   | ADDRESS<br><i>4 WATER WAY CT. APT. 2A</i>  |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Colon Cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>  |   |  |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i></i> P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE   |   |   |   |   |
| 22a. I certify that (1) this hospital attended the deceased from <i>March 25</i> 19 <i>86</i> to <i>March 25</i> 19 <i>86</i> , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on <i>March 25</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) <input type="checkbox"/> I did not view the body after death. |   |  |   |  |   |   |   |   |
| 22b. SIGNATURE<br><i>K R Faulkner</i>  |   | DEGREE<br><i></i>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Kendall R. Faulkner, M.D.</i>  |   | 22e. ADDRESS<br><i>Stella Maris Hospice<br/>2300 Dulaney Valley Rd. - Towson, MD 21204</i>   |   |  |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |   | 23b. DATE<br><i>3-31-86</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>GARRISON FOREST</i>   |   | 23d. LOCATION<br>CITY OR TOWN<br><i>OWING MILLS</i> COUNTY<br><i>MARYLAND</i> STATE |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>WM.C. MARCH F/H INC. 1101 E. NORTH AVE.</i>   |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 27 1986</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Richard R. Riddle</i>                              |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove all non-essential pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.  
IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please return this certificate, page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, a medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | REG. NO. 06981  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |  |  |
| I. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR  |  |  |  |
| Elsie Jones   |  |  |  | March 3, 1986   |  |  |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  |
| Female  |  | Black  |  | MONTH DAY YEAR  |  | 79 YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Maryland  |  | U.S.A.   |  |   |  | BALTIMORE COUNTY, MD.  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| BALTIMORE   |  | VILLA ST. MICHAEL'S NURSING HOME   |  |   |  |  |  |
| 13a STATE   |  | 13b COUNTY   |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| Maryland  |  |  |  | Baltimore   |  | 13e STREET ADDRESS / ZIP CODE  |  |
| FATHER'S NAME   |  | MOTHER'S MAIDEN NAME   |  | 15. ADDRESS   |  |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |   |  |  |  |
| Wesley Scribner   |  | Hattie Pulley  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT  |  |  |  |
| NO  |  | 215-85-7911A   |  | Clarence Scribner 815 Brooks Lane   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE TO   |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10   |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                      |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from JAN 19 86, to March 3, 19 86, that (I) (we) lost saw the deceased alive on February 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b SIGNATURE   |  |  |  | DEGREE  |  | 22c DATE SIGNED  |  |
| L. Reid   |  |  |  | MD  |  | 3/5/86   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e ADDRESS   |  |  |  |
| KUBEN REIDER M.D.   |  |  |  | 914 N. Charles Street Baltimore 21202   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b DATE   |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION CITY OR TOWN COUNTY STATE   |  |
| BURIAL  |  | 3/8/86   |  | Arbutus Cem.  |  | Baltimore Co. Md.  |  |
| 24 FUNERAL DIRECTOR NAME  |  |  |  | 25a DATE REC'D BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE  |  |
| March Funeral Homes 1101 East North Avenue  |  |  |  | MAR 7 1986  |  |  |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|  |  |   |   |   |                              |   |  |
|--|--|---|---|---|------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nettie M Jones</b>          |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>03/27/86</b> |   | 2b. HOUR<br><b>4:30 A.M.</b> |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>05-10-1904</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>County BALTIMORE MD.</b>                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT Home</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>                                      |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>  |                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES A EDWARDS</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LOUISE J SMITH</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |                              | 16b. SOCIAL SECURITY NO.<br><b>219 10 6660</b>  |  |
| 17. INFORMANT<br><b>FAMILY RECORDS</b>                             |  | 17. ADDRESS   |   | 17. ADDRESS   |                              | 17. ADDRESS   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **MENINGITIS**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**CONGESTIVE HEART FAILURE**

MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3/18 1986</b>    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> to <b>3/27</b> 19 <b>86</b> , that (we) lost<br>saw the deceased alive on <b>3/27</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Purushottam Mitra</b>  |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>3-27-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PURUSHOTTAM MITRA</b>   |  |  |  | 22e. ADDRESS<br><b>SJH.</b>   |  |   |  |

|   |  |                               |  |  |  |   |  |
|---|--|-------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                                |  | 23b. DATE<br><b>3-29-1986</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PROVIDENCE CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TOWSON BALTO. MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES HARFORD 8800 ROAD</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>APR 04 1986 juna dardson-henderson</b>     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified to make an autopsy.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Eugenia Kaiser</b>   |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/1/86</b>  |  | 2b. HOUR<br><b>3:10 PM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5/13/22</b>  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>63</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                           |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.                             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>employee</b>          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BG+E</b>   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>A.A.</b> 13c. CITY OR TOWN <b>Sel. PK.</b>   |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SABASTION HOOK</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LENA</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212229364</b>  | 17. INFORMANT ADDRESS<br><b>Louis Kaiser (SAME AS ABOVE #13c)</b>   |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Liver Failure - unknown etiology</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Metastatic Breast Cancer</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>86</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)             |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5601 Loch Raven Blvd, Balt, MD</b> |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/20</b> , 19 <b>86</b> , to <b>3/1</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/1/86, 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) sign the body after death.          |  |   |  |  |  |
| 22b. SIGNATURE<br><b>David R. Weber, MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATESIGNED<br><b>3/1/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID WEBER</b>   |  | 22e. ADDRESS<br><b>5601 Loch Raven Blvd, Balt, MD</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF CREM.)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/5/86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRANE PARK</b>                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Balt, MD</b>  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>BARRANCO FH. 501 RITCHIE HWY SEVERNA PK, MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 06 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

1. The first part of the report is a general description of the area. It is a small, isolated area, and the only access is by a narrow path. The area is surrounded by a dense forest, and the only buildings are a few small huts. The population is small, and the people are of a different race and language from the surrounding area. The area is of great interest to the Government, and it is hoped that the report will be of use to the authorities.

2. The second part of the report is a description of the people. They are a small, isolated group, and they are of a different race and language from the surrounding area. They are very friendly and hospitable, and they are very interested in the outside world. They are very poor, and they live in small huts. They are very hardworking, and they are very brave. They are very loyal to their chief, and they are very devoted to their religion.

3. The third part of the report is a description of the area. It is a small, isolated area, and the only access is by a narrow path. The area is surrounded by a dense forest, and the only buildings are a few small huts. The population is small, and the people are of a different race and language from the surrounding area. The area is of great interest to the Government, and it is hoped that the report will be of use to the authorities.

4. The fourth part of the report is a description of the people. They are a small, isolated group, and they are of a different race and language from the surrounding area. They are very friendly and hospitable, and they are very interested in the outside world. They are very poor, and they live in small huts. They are very hardworking, and they are very brave. They are very loyal to their chief, and they are very devoted to their religion.

5. The fifth part of the report is a description of the area. It is a small, isolated area, and the only access is by a narrow path. The area is surrounded by a dense forest, and the only buildings are a few small huts. The population is small, and the people are of a different race and language from the surrounding area. The area is of great interest to the Government, and it is hoped that the report will be of use to the authorities.

6. The sixth part of the report is a description of the people. They are a small, isolated group, and they are of a different race and language from the surrounding area. They are very friendly and hospitable, and they are very interested in the outside world. They are very poor, and they live in small huts. They are very hardworking, and they are very brave. They are very loyal to their chief, and they are very devoted to their religion.

00-00105

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. Page 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, report the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |                             |   |  |  |  |   |                  | REG. NO. 8 6 0 6 9 8 4                          |  |  |  |  |   |  |  |  |  |   |  |  |                  |
|--|--|---|-----------------------------|---|--|--|--|---|------------------|---|--|--|--|--|---|--|--|--|--|---|--|--|------------------|
| 1. FOR STATE REGISTRAR   |  |   |                             |   |  |  |  |   |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kate Kane</b>   |  |   |                             |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 9, 1986</b>  |  |   | 2b. HOUR<br>M    |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 12 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |   |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1706 Hilltop Ave.</b> |                             |   |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Stamper</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Brush Mfg.</b>              |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Essex</b>   |  |   |                             |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1706 Hilltop Ave. 21221</b>    |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Freyer</b>   |  |   |                             |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Sullivan</b>  |  |   |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214 01 4046</b>  |                             | 17. INFORMANT<br>ADDRESS<br><b>Sue Kane, Daughter in Law</b>  |  |  |  | 17b. <b>Same</b>  |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |                             |   |  |  |  |   |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| MEDICAL CERTIFICATION  |  |   |                             |   |  |  |  |   |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
|  |  |   |                             |   |  |  |  |   |                  |   |  | 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                  |
|  |  |   |                             |   |  |  |  |   |                  |   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |                  |
|  |  |   |                             |   |  |  |  |   |                  |   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |                  |
|  |  |   |                             |   |  |  |  |   |                  |   |  | 22. I certify that (I) (this hospital) attended the deceased from <b>out</b> <b>02</b> to <b>March 9</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>1-27</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |  |   |  |  |  |  |   |  |  | 22c. DATE SIGNED |
| 22b. SIGNATURE<br><i>Nestor M. Carmona</i>   |  |   |                             |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Nestor M. Carmona MD</b>   |  |   |                             |   |  | 22e. ADDRESS<br><b>6012 Harford Rd. Balto. Md. 21214</b>   |  |   |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/12/86</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b> |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave</b>  |  |   |                             |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>          |                  |   |  |  |  |  |   |  |  |  |  |   |  |  |                  |

January, 1963

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 069886

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Tillie Barbara KASHEN</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 27, 1986</b>  |  | 2b. HOUR<br><b>1:35a</b> M  |   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 24 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>---        |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MICHAEL YESCAVAGE</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>---  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>166164624</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JOSEPH E. KASHEN 3920 NEW SECTION RD.</b>                        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension</b>  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 15</b> , 19 <b>86</b> , to <b>March 27</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 27</b> , 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br><i>R. Moushabek</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/27/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Moushabek, M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>03/29/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>                                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD.</b>  |  | 23e. DATE REC'D BY REGISTRAR (15) REGISTRAR'S SIGNATURE<br><b>MAR 27 1986</b> <i>John Davidson</i>  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>John Davidson</i> <b>1211 Chesapeake Ave.</b>  |  |   |  |   |   |

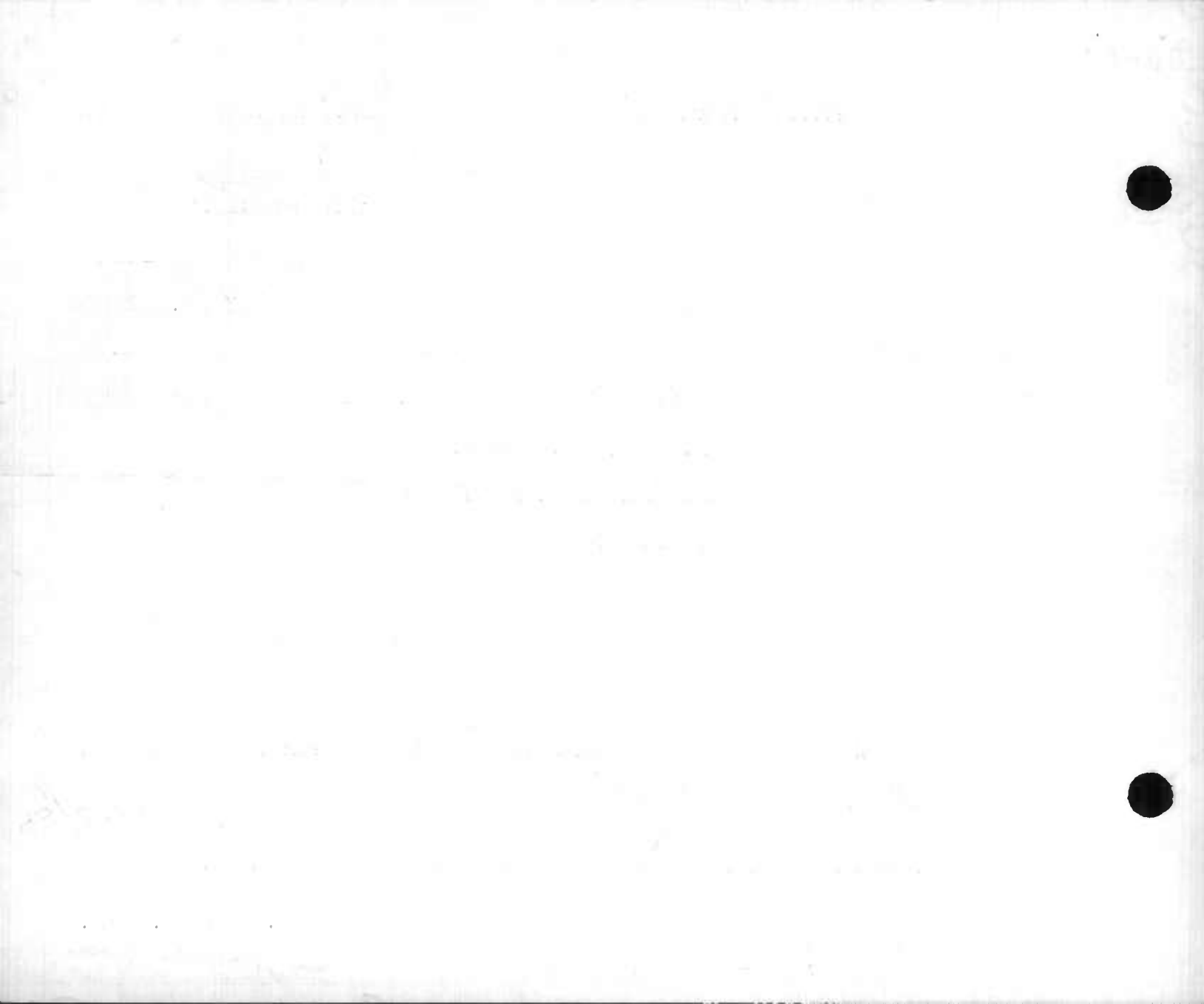
MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-01799

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages found 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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|--|--|--|---|---|--|---|--|--|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |   |  |  |  |
| 1. FOR STATE REGISTRAR   |  |  |   |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Bertha Ketz</i>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>3.21.86</i>   |   | 2b. HOUR<br><i>16:50</i>                                       |  |  |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>Caucasian</i>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>12 6 1890</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><i>95</i>                               |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>POLAND</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE COUNTY</i> MD                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>RANDALLSTOWN</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>BALTO. CO. GEN. HOSP.</i> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>  |  |
| 13a. STATE<br><i>MARYLAND</i>  |  | 13b. COUNTY<br><i>BALTIMORE</i>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><i>3601 FORDS LA., APT. 401 #21215</i>          |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>ABRAHAM GOLDMAN</i>  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>MALKA UNKNOWN</i>  |  |   |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>  |  |  |   | 17. SOCIAL SECURITY NO.<br><i>219-10-0589</i>   |  | 17. INFORMANT ADDRESS<br><i>MRS. EDYTHE KATZ 3601 CLARKS LA., APT. 202</i>        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CARDIAC ARREST (VENTRICULAR FIBRILLATION)</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) <i>SEPSIS, CORONARY ARTERY DISEASE</i>   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>3/16 1986</i>    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)     |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22. I certify that (a) (this hospital) attended the deceased from <i>3/16</i> 19 <i>86</i> to <i>3/21</i> 19 <i>86</i> , that (we) lost the deceased alive on <i>3/21</i> 19 <i>86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Pumshottan Mitra</i>  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><i>3.21.86</i>                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Pumshottan Mitra</i>   |  |  |   |   | 22e. ADDRESS   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |  | 23b. DATE<br><i>3-23-86</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>HEBREW FRIENDSHIP</i>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>BALTIMORE MD</i> |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD., BALTO., MD 21215   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 27 1986</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Guthrie Davidson</i>          |  |  |

WOTIOO 2008

WAX WAX



00-01620

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86  
REG. NO.

06987

1 - FOR STATE REGISTRAR

|   |  |  |  |   |                           |   |  |
|---|--|--|--|---|---------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Samuel - Katz</u>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>03-22-1986</u> |   | 2b. HOUR<br><u>8:46AM</u> |   |  |
| 3. SEX<br><u>male</u>   |  | 4. RACE<br><u>white</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>10 30 1907</u>   |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><u>78</u> YRS                           |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>PENNSYLVANIA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE COUNTY</u> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><u>RANDALLSTOWN</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF DEATH OCCURRED IN STREET ADDRESS)<br><u>BALTO COUNTY GENERAL HOSPITAL</u> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><u>PAINTER</u>   |                           | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>DECORATOR</u>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>MARYLAND</u> |  |  |  | 13b. COUNTY<br><u>BALTO</u>   |                           | 13c. CITY OR TOWN<br><u>OWINGS MILLS</u>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>BENJAMIN KATZ</u>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>JENNIE UNKNOWN</u>  |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>NO</u>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><u>115-10-2434</u>  |                           | 17. INFORMANT<br>ADDRESS<br><u>MICHAEL KATZ 7512 SLADE AVE. 21208</u>                           |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Acute Septic

DUE TO, OR AS A CONSEQUENCE OF

(c) Rt Frontal Cerebral Vascular Accident.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE, FARM, ETC) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-26</u> 19 <u>86</u> to <u>3-22</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3-22</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Allan J. Chircus M.D.</u>   |  |   |  | DEGREE<br><u>M.D.</u>  |  | 22c. DATE SIGNED<br><u>3-22-86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allan J. Chircus M.D.</u>  |  |   |  | 22e. ADDRESS<br><u>Balt. County General Hosp.</u>                                    |  |  |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>                    |  | 23b. DATE<br><u>3/24/86</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>AITZ CHAIM CEM</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTIMORE MARYLAND</u> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>SOL LEVINSON &amp; BROS., INC.</u> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR (b) REGISTRAR'S SIGNATURE<br><u>MAR 27 1986</u> <u>John Burdon-Randall</u> |  |   |  |
| 6010 REISTERS TOWN RD. BALTIMORE, MARYLAND 21215                              |  |                             |  |  |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified and a report filed.



00-00203

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 6 9 8 8

1 - FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |   |  |   |  |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John A. KEEN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 10, 1986</b>           |   | 2b. HOUR<br><b>11:04<sup>a</sup> M</b>   |  |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 3 98</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Sq. 3243 Shannon Drive Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Guard</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Security</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3243 Shannon Drive 21213</b>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                    |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-8385</b>                         |   | 17. INFORMANT<br>ADDRESS <b>3243 Shannon Dr. Mr. Philip Debelius Balto., Md.</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic Cancer of Prostate</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b> |  |  |  |   |  |  |   |  |   |  |
| MEDICAL CERTIFICATION  |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>3/9</b> , 19 <b>86</b> , to <b>3/10</b> , 19 <b>86</b> , that (we) last saw the deceased alive on <b>3/10</b> , 19 <b>86</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.   |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Ronald Attanasio MD</b>   |  |  | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/10/86</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ronald Attanasio, M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>9000 Franklin Square Dr., Balto. 21237</b>                    |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Removal</b>  |  |  | 23b. DATE<br><b>3/11/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |  |  |   | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b> |  | 25. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.



00-01395

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 060606

1- FOR  
STATE  
REGISTRAR

|  |  |                        |  |  |  |   |  |  |  |   |  |  |  |                     |  |
|--|--|------------------------|--|--|--|---|--|--|--|---|--|--|--|---------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Kenneth Stuart Kelly</b>   |  |                        | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>3/ 22/ 1986</b> |  |  | 2b. DATE OF DEATH<br>MONTH DAY YEAR <b>3/ 22/ 19 86</b> |  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>3/ 22/ 19 86</b> |   |  | 2d. HOUR <b>5:29</b>   |  |                     |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Cauc.</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3/18/57</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>29</b> YRS.        |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |  | IF UNDER 24 HRS.<br>HOURS MIN                             |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>3/ 22/ 19 86</b>           |  | 7d. HOUR <b>A M</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  |                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, Md.</b>     |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  |                        |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9825 Foxhill Rd.</b>  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Body &amp; Fender Man Body Sh.</b>   |  |   |  | 12b. KNOWN BUSINESS OR INDUSTRY<br><b>Body &amp; Fender Man Body Sh.</b> |  |                     |  |
| 13a. STATE<br><b>Md.</b>   |  |                        |  | 13b. CITY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>9825 Foxhill Rd. Perry Hall</b> |  |  |  |                     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Stuart Kelly</b>   |  |                        |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marjorie Daugherty</b>  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-70-8321</b>                           |  |                     |  |
| 17 INFORMANT<br><b>Marjorie Kelly, same address</b>  |  |                        |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shotgun Wound to Head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Shotgun Wound to Head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Shotgun Wound to Head</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |  |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |                        |  |  |  |   |  |  |  |   |  |  |  |                     |  |
| 19a. DATE OF OPERATION   |  |                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |                     |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                        |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 3/21/ 19 86</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>selft inflicted wound</b>  |  |   |  |  |  |                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                        |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>garage</b>   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>9825 Foxhill Rd., Balto. County, Md.</b>   |  |   |  |  |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                        |  |  |  |   |  |  |  |   |  |  |  |                     |  |
| ACTUAL SIGNATURE<br><b>Gregory R. Kauffman, M.D.</b>   |  |                        |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>3/22/86</b>   |  |   |  |  |  |                     |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |                        |  | ADDRESS<br><b>111 Penn St.</b>   |  |   |  |  |  |   |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  |                        |  | 23b. DATE<br><b>3/25/85</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Joseph's Cemetery, Balto., Md.</b>  |  |   |  |  |  |                     |  |
| 24. <b>Schlimmek Funeral Home, Inc.</b>  |  |                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Rondelle</b>   |  |   |  |  |  |                     |  |
| 26. <b>9705 Belair Rd., Balto., Md. 21236</b>  |  |                        |  |  |  |   |  |  |  |   |  |  |  |                     |  |

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25MBP  
DHMH - 17  
(VR A15 ME (5))

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11/11/14

11/11/14



00-01117

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 6 9 9 0

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret Mary KEMP   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 18, 1986   |  | 2b. HOUR<br>p<br>1:56<br>M   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 4, 1895                                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90<br>YRS.  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County<br>MD.                      |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Parkville   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Ledlich   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pauline Hillenmeyer  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 26 4301  |  | 17. INFORMANT<br>ADDRESS<br>Edna A. Erb 734 Sue Grove Rd. 21221                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest from Ventricular Arrhythmia<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (this hospital) attended the deceased from 3/18 19 86, to 3/18 19 86, that (we) last saw the deceased alive on 3/18 19 86, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br>P. A. Baltatzis M.D.  |  |   |  | 22c. DATE SIGNED<br>3-18-86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. A. Baltatzis, M.D.  |  |   |  | 22e. ADDRESS<br>9000 Franklin Sq. Dr., Balto., 21237                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>Burial  |  | 23b. DATE<br>3/20/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                         |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, Md.   |  | 23e. NAME OF CEMETERY OR CREMATORY<br>Baltimore City, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.   |  |   |  | 25a. DATE REGD. BY REGISTRAR<br>21 1986  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |   |  | 25c. REGISTRAR'S SIGNATURE   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/1  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2500

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## Results

28

7255 of 1950

[illegible]

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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• **Intermittent** – occurs at irregular intervals

ISSN 0013-788X

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 9 1

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |                              |  |
|---|--|---|--|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Helen L. KEOUGH</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 16, 1986</b> |  | 2b. HOUR<br><b>4:20 a.m.</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 13, 1909</b>  |                              |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 8. AGE UNDER 1 YEAR<br>MONTHS DAYS<br><b>76</b>  |                              |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b>   |                              |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Federal Reserve Bank-</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Richmond</b>  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Md. Baltimore</b>   |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles P. McNally</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Rose Estelle Connelly</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |                              |  |
| 16b. SOCIAL SECURITY NO.<br><b>220-34-7313</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Herbert L. Keough Jr. 8722 Maravoff Lane</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |   |  |  |                              |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                              |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 12, 1986</b> to <b>March 16, 1986</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 16, 1986</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. |  |   |  |  |                              |  |
| 22b. SIGNATURE<br><b>G. Sloan</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/16/86</b>   |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Geoffrey Sloan, M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |  |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Mar. 20, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>   |                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  | 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |  |                              |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                              |  |

MEDICAL CERTIFICATION

Leonard J. Bush Inc., Baltimore, Maryland

00-005301

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 9 2

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Elizabeth C. Kern</b>   |  | 2a DATE OF DEATH<br>MONTH <b>3</b> DAY <b>15</b> YEAR <b>86</b>  |  | 2b HOUR<br><b>8:00A</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>24</b> YEAR <b>84</b>                         |  |
| 6a BIRTHPLACE (STATE OR FOREIGN)<br><b>Baltimore, MD</b>   |  | 6b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6c AGE (IN YEARS LAST BIRTHDAY)<br><b>101</b>  |  |
| 7a CITY OR TOWN OF DEATH<br><b>Dulaney Valley</b>  |  | 7b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b>                            |  | 7c BALTIMORE CITY OR COUNTY OF DEATH<br><b>Towson, Maryland</b>                        |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Towson, Maryland</b>   |  | 10 USUAL OCCUPATION<br>(BY MOST OF WORKING LIFE)<br><b>Home Maker</b>                  |  |
| 11a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>11b STATE <b>MD</b> 11c COUNTY <b>Towson</b>  |  | 12a INSIDE CITY LIMITS?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>  |  | 12b STREET ADDRESS, ZIP CODE<br><b>4009 Overlea Avenue 21206</b>                       |  |
| 13 FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>C.</b> LAST <b>Kern</b>   |  | 14 MOTHER'S MAIDEN NAME<br>FIRST <b>Bergman</b> MIDDLE <b>Bergman</b> LAST <b>Bergman</b>  |  |  |  |
| 15a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 15b SOCIAL SECURITY NO.<br><b>218-52-0573</b>  |  | 15c INFORMANT<br><b>Mrs. William C. Gordon</b>   |  |
| 16a ADDRESS<br><b>1010 Overlea Ave</b>   |  | 16b ADDRESS<br><b>Baltimore, Maryland</b>  |  | 16c ADDRESS<br><b>21206</b>  |  |
| 17 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Advanced Arteriosclerotic Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |
| 18a DATE OF OPERATION  |  | 18b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 18c AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 19a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 19b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <b>86</b>  |  | 19c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |
| 20a INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 20b PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 20c LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |
| 21 I certify that (I) (this hospital) attended the deceased from <b>March 14, 1986</b> to <b>March 15, 1986</b> , that (I) (we) last saw the deceased alive on <b>March 15, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |
| 22a SIGNATURE<br><b>DR. E. Nakhuda MD</b>  |  | 22b DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>MAR 17 1986</b>  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>3-18-86</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                         |  |
| 23d LOCATION<br>CITY OR TOWN<br><b>Baltimore, Md.</b>  |  | 23e COUNTY<br><b>Baltimore</b>   |  | 23f STATE<br><b>Md.</b>  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>John Miller</b>  |  | 24b ADDRESS<br><b>6415 Belair Rd. -21206</b>   |  | 24c DATE REC'D. BY REGISTRAR<br><b>MAR 17 1986</b>                                     |  |
| 24d REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  | 24e REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  |

MEDICAL CERTIFICATION

9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



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00-00679

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 9 3

REG. NO.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET A. KERNS</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 14 86</b>                                  |   | 2b. HOUR<br><b>11:20p M</b>                                  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 25 1897</b>   |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>88</b><br>YRS. MONTHS DAYS HOURS MIN.                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Summit Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chief Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O Railroad</b> |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Halethorpe</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John B. Kerns</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Pease</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>705-03-8037</b>   |  | 17. INFORMANT ADDRESS<br><b>Margaret M. Rodenhi, 35 Oaklee Village 21229</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced Atherosclerotic CVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)                 |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>9/16 19 77</b> to <b>3/14 19 86</b> that (1) was lost<br>seen to be dead alive or<br>otherwise (if deceased died not within the body after death)   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Herbert J. Levickas</b>  |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/17/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Herbert J. Levickas</b>   |   | 22e. ADDRESS<br><b>5404 East Drive, Balto., Md. 21227</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>3/18/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc., 4107 Wilkens Ave. 21229</b>   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. M. Anderson-Rondelet</b>   |  |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 6 9 9 4

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARGARET MIDDLE M LAST KILMURRY<br><i>MARGARET M KILMURRY</i>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>03-04-86</i>   |  | 2b. HOUR<br><i>7<sup>00</sup> AM</i>  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Caucasian</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8-22-98</i>  |  |
| 6. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S. USA</i>  |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br><i>87 yrs.</i> YRS MONTHS DAYS HOURS MIN.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>ROSEDALE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>MANOR CARE ROSSVILLE</i> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. County MD.</i>  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>   |  | 13a. STREET ADDRESS / ZIP CODE<br><i>21220</i>  |  |
| 14. FATHER'S NAME<br>FIRST John MIDDLE LAST HARDY   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Mary MIDDLE UNKNOWN LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>no</i>   |  |
| 16b. SOCIAL SECURITY NO.<br><i>213-20-6962</i>  |  | 17. INFORMANT<br><i>Patrick Kilmurry Jr. same address</i>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>- cerebral-vascular accident</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><i>- old C.V.A. with left hemiplegia. As CVO</i> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/10/82</i> to <i>3/4/86</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3/4/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><i>M.D.</i>  |  | 22c. DATE SIGNED<br><i>3-5-86</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DR. TUN</i>   |  | 583-8130   |  | 22e. ADDRESS<br><i>1006 Taylor Ave: Md 21204</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3-7-86</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore National Cem. Balto., Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br><i>Schimunek Funeral Home, Inc.</i>   |  | 25. DATE RECEIVED BY REGISTRAR<br><i>MAR 7 1986</i>  |  | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |
| 3331 Brehms Lane, Balto., Md.   |  | 21213  |  |   |  |

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00-01639

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
1- STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                      |   |   |   |   |   |   |   |
|---|----------------------|---|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William Edward Kinsley  |                      |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>3 24 19 86     |   |   | 2b. HOUR<br>M<br>11:02 a  |   |   |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/5/15  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                  | 7. IF UNDER 1 YR.<br>MONTHS DAYS  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 24 19 86                  |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.              |   |   |
| 11. CITY OR TOWN OF DEATH<br>Randallstown   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County General Hospital |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Maryland Cup |
| 13a. STATE<br>Maryland  |                      |   | 13b. CITY<br>Baltimore                                      | 13c. CITY OR TOWN<br>Pikesville   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>914 Adana Road 21208                               |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Reuben Kinsley  |                      |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lizetta Lang   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |                      | 16b. SOCIAL SECURITY NO.<br>WWII<br>212-01-5475   |   | 17. INFORMANT ADDRESS<br>Mrs. Madelynne Kinsley 914 Adana Road Pikesville, MD   |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                      |   |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Alzheimer's disease</u>   |                      |   |   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |                      |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |   |   |   |   |   |   |   |
| ACTUAL SIGNATURE<br>  |                      |   | TITLE (SPECIFY)<br>Assistant MEDICAL EXAMINER               |   |   | DATE SIGNED<br>3/25/86  |   |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.  |                      |   | ADDRESS<br>111 Penn St. Balto.MD.                           |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |                      | 23b. DATE<br>3/27/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Memorial Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville Carroll Maryland |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>8728 Liberty Road Randallstown, MD. 21133<br>Loring Byers Funeral Directors, Inc.   |                      |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1986  |   | 25b. REGISTRAR'S SIGNATURE<br>  |   |   |



00-01282

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |                         |   |  |   |   |  |  |  |
|---|-------------------------|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph George Kirwan</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>3 22 19 86</b> |   |   | 2b. HOUR<br>M <input type="checkbox"/> A <input checked="" type="checkbox"/> P <input type="checkbox"/><br><b>11 A</b> |  |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 19 1935</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>51</b> YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>3 22 19 86</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b> Md. </b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b> USA </b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b> Baltimore County </b> MD.  |  |  |
| 11. CITY OR TOWN OF DEATH<br><b> Chase </b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b> 36 Freedom Court </b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b> Clerk </b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b> Maryland </b>   |                         |   | 13b. COUNTY<br><b> Balto. </b>   | 13c. CITY OR TOWN<br><b> Chase </b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b> 36 Freedom Court 21027 </b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b> George Kirwan </b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b> Agnes Dobial </b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b> no </b>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b> 216-32-2833 </b>   |  | 17. INFORMANT ADDRESS<br><b> Priscilla Kirwan 36 Freedom Court 21027 </b>   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b> CAUSE OF pulmonary Arrest </b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b> Probable Ventricular Arrhythmia </b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b> Suspected Myocardial INFARCTION </b> |                         |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |                         |   |  |   |   |  |  |  |
| ACTUAL SIGNATURE<br><b> J. M. Nieto </b>  |                         | TITLE (SPECIFY)<br><b> M.D. </b>  |  | MEDICAL EXAMINER  |   | DATE SIGNED <b> 3/22/86 </b>   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b> J. M. Nieto </b>  |                         | ADDRESS <b> 6800 MORNINTON RD. BALTO, M. 21222 </b>   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b> Burial </b>   |                         | 23b. DATE<br><b> 3/26/86 </b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b> Bohemian National </b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b> Baltimore Maryland </b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b> Connelly Funeral Home 300 Mace Ave. 21221 </b>  |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b> MAR 24 1986 </b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b> David R. ... </b>  |  |  |

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

11 38 56 2  
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070042

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

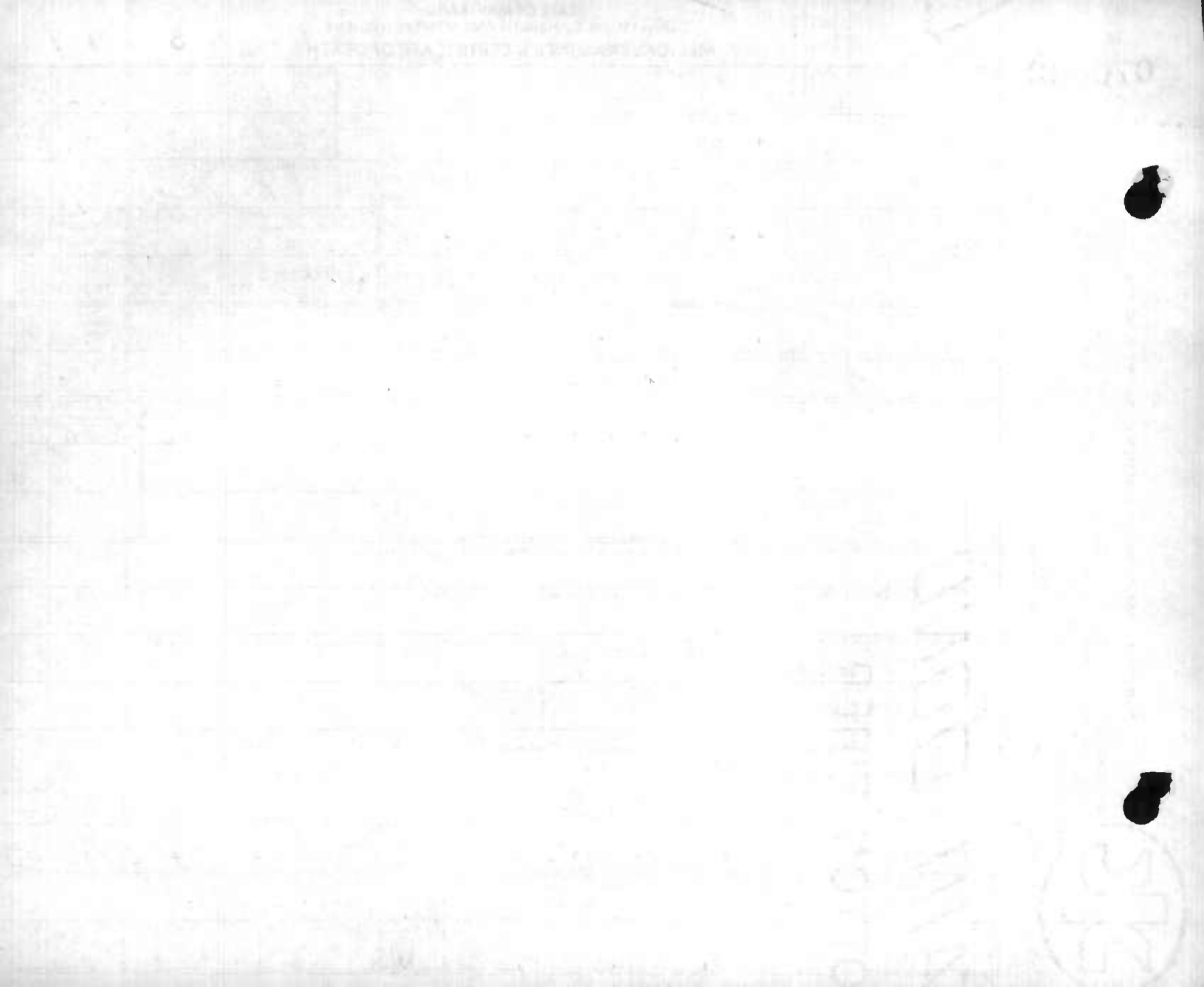
REG. NO.

06997

|   |         |   |  |  |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
|---|---------|---|--|--|--|---|--|--|--|--|--|---------------|--|---------------|--|---------------|--|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH                   |  | ESTIMATED                                    |  | MONTH         |  | DAY           |  | YEAR          |  | 2b. HOUR      |  |
| Dolores   |         | Virginia  |  | Klein  |  |   |  | 3  |  | 3  |  | 19            |  | 86            |  | 12            |  | M             |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                             |  | 2c. DATE                                     |  | MONTH         |  | DAY           |  | YEAR          |  | 2d. HOUR      |  |
| Female  | White   | 01 22 22  |  | 66 YRS.  |  |   |  |  |  | 3  |  | 3             |  | 19            |  | 86            |  | 12            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED   |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |  |  |               |  |               |  |               |  |               |  |
| MD  |         | USA   |  | WIDOWED  |  | DIVORCED  |  | BALTO County                                 |  |  |  |               |  |               |  |               |  |               |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| Catonsville   |         | 1310 McCurley Avenue 21228                                  |  | Homemaker  |  | Home  |  |  |  |  |  |               |  |               |  |               |  |               |  |
| 13a. STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |  |  |               |  |               |  |               |  |               |  |
| MD  |         | Baltimore   |  | Catonsville  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1310 McCurley Avenue                         |  |  |  |               |  |               |  |               |  |               |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                    |  |  |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| Barney  |         | B. Klein  |  | Virginia   |  | Getz  |  |  |  |  |  |               |  |               |  |               |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| NO  |         | 217-74-4448   |  | Agnes T. Brittingham                                     |  | Same as #13   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |         | PART I DEATH WAS CAUSED BY:                                 |  | IMMEDIATE CAUSE (a)                                      |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |               |  |               |  |               |  |               |  |
|   |         |   |  | A.S.C.U.D.   |  |   |  | 10 MIN                                       |  |  |  |               |  |               |  |               |  |               |  |
|   |         |   |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |  |  |               |  |               |  |               |  |               |  |
|   |         |   |  | (c)  |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |         |   |  |  |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?   |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
|   |         |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| 21a. EXTERNAL CAUSE WAS   |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED                                 |  | 21d. PLACE OF INJURY  |  | 21e. LOCATION                                |  | 21f. LOCATION                                |  | 21g. LOCATION |  | 21h. LOCATION |  | 21i. LOCATION |  | 21j. LOCATION |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | HOUR A.M. MONTH DAY YEAR                                    |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2       |  | P.M. 19   |  | STREET                                       |  | CITY OR TOWN                                 |  | COUNTY        |  | STATE         |  |               |  |               |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION  |  | 21g. LOCATION   |  | 21h. LOCATION                                |  | 21i. LOCATION                                |  | 21j. LOCATION |  | 21k. LOCATION |  | 21l. LOCATION |  | 21m. LOCATION |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |         |   |  | STREET   |  | CITY OR TOWN  |  | COUNTY                                       |  | STATE  |  |               |  |               |  |               |  |               |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |   |  |  |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| 22a. I certify that I took charge of the remains described above, held an   |         | Autopsy <input type="checkbox"/>                            |  | Inspection <input checked="" type="checkbox"/>           |  | Inquiry <input checked="" type="checkbox"/>                         |  | and in my opinion                            |  |  |  |               |  |               |  |               |  |               |  |
| death resulted from   |         | Natural causes <input checked="" type="checkbox"/>          |  | Accident <input type="checkbox"/>                        |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input type="checkbox"/>            |  | Undetermined manner <input type="checkbox"/> |  |               |  |               |  |               |  |               |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |  | MEDICAL EXAMINER   |  | DATE SIGNED   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| E. P. Williams  |         | M.D. Defory   |  |  |  | 3/3/86  |  |  |  |  |  |               |  |               |  |               |  |               |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS   |  |  |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| E. P. Williams MD   |         | 5550 BALTO NAT'L PK 21278                                   |  |  |  |   |  |  |  |  |  |               |  |               |  |               |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  | 23d. LOCATION   |  | 23e. LOCATION                                |  | 23f. LOCATION                                |  | 23g. LOCATION |  | 23h. LOCATION |  | 23i. LOCATION |  | 23j. LOCATION |  |
| Burial  |         | 03/07/86  |  | New Cathedral Cem.                                       |  | Baltimore City  |  | COUNTY                                       |  | STATE  |  |               |  |               |  |               |  |               |  |
| 24. FUNERAL DIRECTOR  |         | NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                   |  |  |  |               |  |               |  |               |  |               |  |
| MacNabb Funeral Home  |         | Catonsville, MD   |  |  |  | MAR 7 1986  |  | Randell                                      |  |  |  |               |  |               |  |               |  |               |  |

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82



00-01390

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Aida B. Klein-Adelhardt</b>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-17-86</b>   |  | 2b HOUR<br><b>3:45 PM</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 27 06</b>                        |  |
| 6a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b><br>YRS MONTHS DAYS               |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. Joseph Hospital</b>              |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD            |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |  |  |
| 13a STATE<br><b>MD.</b>  |  | 13b COUNTY<br><b>Baltimore</b>   |  | 13c STREET ADDRESS / ZIP CODE<br><b>5722 Rock Spring Rd. 21209</b>           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick W. Klein</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida B. B. Mariner</b>   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-01-2382</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>Mary June Lange -907 Stagshead Rd. 21204</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cervical Carcinoma with</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ureteral obstruction</b> |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>2/19/86</b> , 19____, to <b>3/17/86</b> , 19____, that (I) (we) last saw the deceased alive on <b>3/17/86</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                                    |  |  |  |  |  |
| 22b SIGNATURE<br><b>Kamala</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br><b>3/17/86</b>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KAMALA</b>  |  | 22e ADDRESS  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>3-19-86</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>                 |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 21 1986</b>                           |  |
|  |  | 25b REGISTRAR'S SIGNATURE  |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

2025-01-01



072171

1- FOR  
STATE  
REGISTRAR

Louise Helen Knight

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 6 9 9 9

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Louise H Knight</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>3-9-86</b>   |  | 2b. HOUR<br><b>1:10 AM</b>                                    |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10-5-1900</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HOSPITAL, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Practical Nurse</b>      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing Home</b>   |   |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>6220 Northwood Dr. / 21212</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christ Jensen</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Stern</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217/18/0692A</b>   |   | 17. INFORMANT ADDRESS<br><b>Louise A. Cerino (sama as 13e.)</b>  |   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CUA (Lt)</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cerebral Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>COPD, Diabetes mellitus, congestive heart failure</b>   |  |   |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)   |   |  |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-23</b> , 19 <b>86</b> , to <b>3-9</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3-9</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Pv Kanani</b>   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/9/86</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KANANI</b>   |  | 22e. ADDRESS<br><b>St. Joseph Hospital</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  | 23b. DATE<br><b>3/10/1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Brooks Bradley Inc. Balto., Md. 21222</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1986</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>L. A. Cerino</b>   |  |   |

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION: If item 21 is marked for item 18, show any injury or other traumatic event, the medical condition, and the nature of the injury or other traumatic event.

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 will be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked for item 18, show any injury or other traumatic event, the medical condition, and the nature of the injury or other traumatic event.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>ANDREI  |  | MIDDLE<br>KOPP  |  | LAST<br>KOPP  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 29, 1986   |  | 2b. HOUR<br>10:46 PM  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 7, 1934  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>RUSSIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MACHINIST   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MARTIN MARRIETTA   |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>PIKESVILLE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13. STREET ADDRESS / ZIP CODE<br>4787 BYRON RD. ( 21208)  |  |   |  |
| 14. FATHER'S NAME<br>GEORGE  |  | MIDDLE<br>KOPP   |  | LAST<br>KOPP  |  | 15. MOTHER'S MAIDEN NAME<br>ANNIE   |  | MIDDLE<br>UNKNOWN   |  | LAST<br>UNKNOWN   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>104-60-4003   |  | 17. INFORMANT<br>MRS. IDA KOPP  |  | ADDRESS<br>4787 BYRON RD. ( 21208)  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Acute MI</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Hypertension</u>   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>minutes</u><br><u>years</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE   |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>4/14</u> 19 <u>81</u> to <u>3/29</u> 19 <u>86</u> , that (1) (we) last<br>saw the deceased alive on <u>11/10</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>S.H. MACIN</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br>3/31/86   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S.H. MACIN  |  | 22e. ADDRESS<br>3635 Old Court Rd (21208)  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>3/31/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW  |  | 23d. LOCATION<br>CITY OR TOWN<br>REISTERSTOWN, BALTO., MD.                                      |  | COUNTY  |  | STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  | 25a. DATE REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>   |  |   |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner will be notified and the coroner advised.

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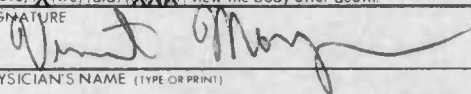



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William C. KRAHLING</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 20, 1986</b>                                |   | 2b. HOUR<br><b>11:00p<sub>M</sub></b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 3, 1919</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.- Beth Steel</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Foreman</b>  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3309 Mary Ave. 21214</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Krahling</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Vorndran</b>                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 11</b>   |   | 17. INFORMANT ADDRESS<br><b>Mrs. Helen M. Krahling Same as 13E</b>                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest, Hypercarbia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Chronic Obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>10</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 6</b> , 19 <b>86</b> , to <b>March 20</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 20</b> , 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (XXX) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |   |   | 22c. DATE SIGNED<br><b>3-20-86</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Vincent Morgan, M.D.</b>   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-24-86</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |  |   | ADDRESS<br><b>Baltimore, Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1986</b>  |
|  |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>        |

MEMORANDUM

Dec. 3, 1919

MEMO

TO :

U.S.A.

Mr. [Name]

Mr. [Name] - [Address]

Mr. [Name] - [Address]

Mr. [Name]

1919 [Address]

X

[Text]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

RECEIVED

[Handwritten notes]

[Handwritten signature]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

7 072056

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>BARBARA L. KRAMER   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 6, 1986                   |  | 2b. HOUR<br>5:56A. M  |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 10, 1930   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 72 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.  |  | 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>9309 SAMOSET RD. 21133                         |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME                           |  | 13a. STREET ADDRESS / ZIP CODE<br>9309 SAMOSET RD. 21133  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>RANDALLSTOWN   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BILL HARLEY   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FLORENCE WEINER       |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |
| 16b. SOCIAL SECURITY NO.<br>218-26-2563   |  | 17. INFORMANT<br>MR SYLVAN KRAMER                                      |  | ADDRESS<br>RANDALLSTOWN 9309 SAMOSET RD. 21133  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Extensive pulmonary metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Renal carcinoma</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>84</u> , to <u>March</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Feb. 28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>3/6/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. HUBBARD   |  | 22e. ADDRESS<br>22 S. GREENS ST., BALTO, MD 21201                      |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/7/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW YOUNG MEN CEM  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MARYLAND  |  | 24. FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.             |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1986  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  | 26. 6010 REISTERSTOWN RD. BALTO, MD 21215                              |  |   |  |

MAILED  
JUL 10 1964

Copy of report  
submitted to the  
State Commission

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Aug 26

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1- FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 0 3

REG. NO.

|  |  |   |   |   |   |  |   |  |  |  |
|--|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Harry Webb Kreimer</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 23 1986</b>                   |   |   | 2b. HOUR<br><b>4:05 A.M.</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 19 1904</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic-Crown</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cork &amp; Seal</b>  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Balto. City</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3315 Croydon Road 21207</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                 |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-09-8016</b> |   |   | 17. INFORMANT<br><b>Mrs. Hollie Kreimer</b> ADDRESS<br><b>3315 Croydon Rd. Baltimore Maryland 21207</b>  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Colon with</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Liver metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 28, 1986</b> to <b>March 23, 1986</b> , that (I) (we) last saw the deceased alive on <b>March 23, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sharon Pourmottabed M.D.</b>  |  |   |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3-23-86</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GHASSEM POURMOTABED</b>  |  |   |   |   |   | 22e. ADDRESS<br><b>Balto. Co. Gen. Hospital</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>03-26-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. City Maryland</b>                       |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

LIBRARY

20% COTTON

11/17/11

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00-00274

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 0 4

REG. NO.

|   |                  |  |  |   |  |
|---|------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THELMA P. KREITZBURG   |                  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 13 86 |   | 2b. HOUR<br>4:30 A.M.  |
| 3. SEX<br>Female  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 11 06   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Home Catonsville       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk                       |  |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY<br>Baltimore   | 13c. CITY OR TOWN<br>Essex                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Bloom  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNAVAILABLE   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>NO   |                  | 16b. SOCIAL SECURITY NO.<br>220-10-8900  |  | 17. INFORMANT<br>ADDRESS<br>Harry Kreitzburg, Jr. 112 Second Ave. 21227                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Infection</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chorea</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.              |                  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>10 days</u>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |  |   |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 7</u> , 19 <u>86</u> , to <u>March 13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>March 12</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |                  |  |  |   |  |
| 22b. SIGNATURE<br><u>David R. Mosman</u>  |                  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3-15-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mosman, David R.   |                  | 22e. ADDRESS<br>5205 East Drive Annapolis, Md 21227  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |                  | 23b. DATE<br>3/15/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process Crem.                                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto. Md.  |                  | 23e. DATE RECD. BY REGISTRAR   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc.  |                  | ADDRESS<br>21229<br>4107 Wilkens Ave.  |  | 25a. DATE RECD. BY REGISTRAR<br>MAR 14 1986   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Jana M. [Signature]</u>  |                  |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





00-01116

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM RW-3, RETURN PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |   |  |   |  | REG. NO. 07005  |  |   |  |  |  |  |  |  |  |
|---|--|-------------------------|--|--|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Walter Thomas Krenseavage</b>  |  |                         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR<br><b>3 20 86</b>            |  | 2b. HOUR<br><b>A M</b>  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 19, 1915</b>  |  | 6. AGE (IN YEARS) LAST BIRTHDAY YRS.<br><b>70</b>                                       |  | IF UNDER 1 YR. MONTHS DAYS<br><b>0 0</b>  |  | IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>                           |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>3 20 86</b>             |  | 2d. HOUR<br><b>1:30 P M</b>              |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD. |  |   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>22 Blister St. 21220</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Counselor</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>School</b>                    |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                         |  |  |  |   |  |   |  | 13a. STATE<br><b>Maryland</b>                                       |  | 13b. COUNTY<br><b>Baltimore</b>                                       |  | 13c. CITY OR TOWN<br><b>Middle River</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>22 Blister St. 21220</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank Krenseavage</b>   |  |                         |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna Onuchak</b>   |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>179-18-2871</b>   |  | 17. INFORMANT ADDRESS<br><b>Christina R. Chilcote 8 Still Pond Ct. New Freedom, Pa.</b> |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>SUDDEN CARDIAC DEATH</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PROBABLE VENTRICULAR ARRHYTHMIA</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .              |  |                         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>J. M. Nichols</b>  |  |                         |  | TITLE (SPECIFY)<br><b>M.D.</b>   |  |   |  | MEDICAL EXAMINER<br><b>J. M. Nichols</b>  |  |   |  | DATE SIGNED<br><b>3/20/86</b>   |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>J. M. Nichols</b>   |  |                         |  | ADDRESS<br><b>6800 MORNINGTON RD. BALTO, MD 21222</b>  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>3-24-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>                        |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Ringtown, Pa.</b>     |  |   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. MAR 21 1986</b>  |  |                         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1986</b>   |  |                         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. M. Nichols</b>  |  |                         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |

BP

White Thomas

White Nov. 10, 1913

Commissioner of the State of New York

Albany, New York

Dear Sir:

Frank Armstrong

123-12-1

Enclosed for you are two copies of a report of the State of New York for the year 1913. The report contains a full and complete statement of the condition of the State at the end of the year, and of the progress made during the year in the various departments of the State government. It also contains a full and complete statement of the condition of the State at the end of the year, and of the progress made during the year in the various departments of the State government.

I am, Sir, very respectfully,  
Your obedient servant,  
Albion D. Williams,  
Commissioner of the State of New York.

Very truly yours,  
Albion D. Williams,  
Commissioner of the State of New York.

Albion D. Williams,  
Commissioner of the State of New York.

Albion D. Williams,  
Commissioner of the State of New York.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-01456

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove container papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B then any injury, or other traumatic event, the medical examiner must be notified at once.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 6 0 7 0 0 6  |  |  |  |
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <i>Melie R Kriete</i>  |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 21 1986</i>   |  | 2b HOUR<br><i>35</i><br>P M  |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>W</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 07 1899</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>86</i><br>YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>VA</i>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CO.</i> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><i>TOWSON</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>ST. JOSEPH HOSPITAL</i> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>  |  |
| 12b KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 1212   |  |  |  |
| 13a STATE<br><i>Md.</i>   |  | 13b COUNTY<br><i>Baltimore</i>  |  | 13c CITY OR TOWN<br><i>Baltimore</i>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |
| 13e STREET ADDRESS / ZIP CODE<br><i>113 Dumbarton Road Apt C.</i>   |  |   |  |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John T. Robertson</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Laura Jane Wood</i>  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>216-09-5656</i>  |  | 17 INFORMANT ADDRESS<br><i>Mrs. Jane K. Awalt 2207 Westridge Road 21093</i>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Ischemia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Stenosis and Coronary Atherosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i>   |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <i>he</i> (this hospital) attended the deceased from <i>3/16</i> 19 <i>86</i> , to <i>3/21</i> 19 <i>86</i> , that <i>he</i> (we) lost saw the deceased alive on <i>3/21</i> 19 <i>86</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>He</i> (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Lester A. Wall Jr MD</i>   |  |   |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><i>3/21/86</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>LESTER A. WALL JR MD</i>  |  |   |  | 22e. ADDRESS<br><i>7620 York Rd Towson MD 21204</i>  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b DATE<br><i>3/24/86</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Memorial</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Dorsey, Md.</i>   |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</i>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 26 1986</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

111

NOTICE

111



00-01971

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |  |
|---|--|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>YETTA BELLA KRUGER  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 28, 1986                    |  | 2b HOUR<br>9:20A. M                                      |  |
| 3 SEX<br>FEMALE   |  | 4 RACE<br>CAUCASIAN   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>AUG. 15, 1901   |  |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>RUSSIA   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br>OWNER |  |  |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br>CONFECTIONARY STORE   |  |   | 10 CITY OR TOWN OF DEATH<br>RANDALLSTOWN                                |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3 KISKA CT. 21133  |  |   | 13a STATE<br>MARYLAND   |  |  |  |
| 13b COUNTY<br>BALTIMORE   |  |   | 13c CITY OR TOWN<br>RANDALLSTOWN  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>LEVI YITZHAK MISHNE  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CHANA ROCHEL RABIN      |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-34-4293A  |  |  |  |
| 17 INFORMANT<br>MRS. ZILLAN EZRA  |  |   | 3 KISHKA CT. RANDALLSTOWN, MD 21133                                     |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic cancer to liver</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Primary site undetermined</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 months |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Arteriosclerotic heart disease with congestive heart failure</u>   |  |   |   |  |  |  |
| 19a DATE OF OPERATION<br>0  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br>C  |   | 20a AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 20b IF YES, WERE FINDINGS CAUSED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |  |  |  |
| 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Aug 21, 1971</u> to <u>March 28, 1986</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>March 5, 1986</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(do)</u> <del>(did not)</del> view the body after death.                    |  |   |   |  |  |  |
| 22b SIGNATURE<br><u>Marvin Goldstein,</u>   |  | DEGREE<br>MD  |   | 22c DATE SIGNED<br>March 28/1986   |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARVIN GOLDSTEIN  |  | 22e ADDRESS<br>6001 Park Heights Ave. Balto, MD 21215   |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b DATE<br>3/30/86   |   | 23c NAME OF CEMETERY OR CREMATORY<br>FORBAND   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS., INC.   |  | ADDRESS<br>6010 REISTERSTOWN RD. BALTO, MD 21215  |   | 25a DATE RECEIVED BY REGISTRAR<br>APR 01 1986  |  |  |
| 25b REGISTRAR'S SIGNATURE<br><u>Jake Darden-Randall</u>   |  | 25c REGISTRAR'S SIGNATURE<br><u>Jake Darden-Randall</u>   |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled into the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove other papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text, possibly a title or description, written in cursive script.

Handwritten text, possibly a title or description, written in cursive script.

Handwritten text, possibly a title or description, written in cursive script.

00-00280

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

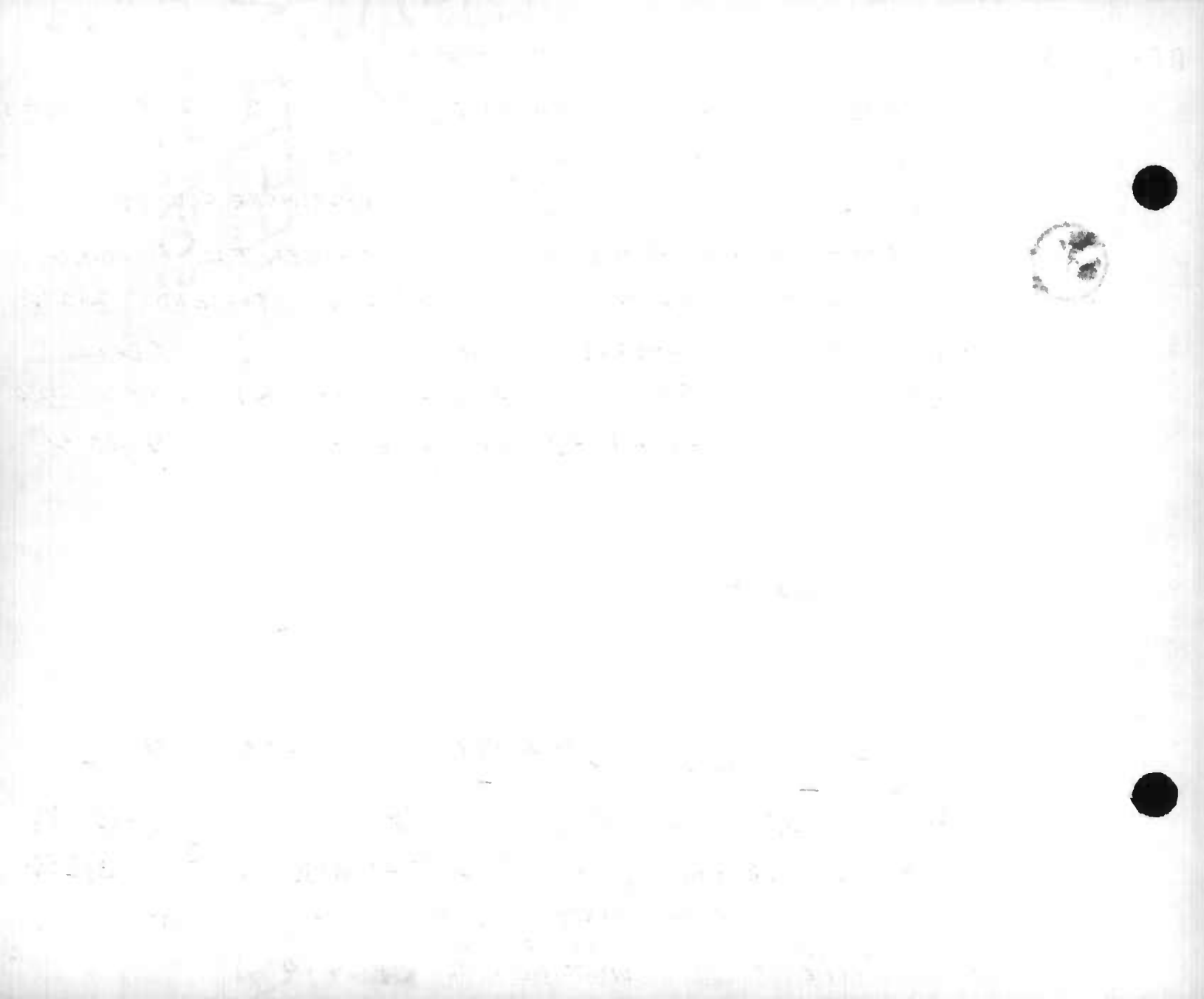
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  | REG. NO.   |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JESSE A. LAMBERT</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>12</b> YEAR <b>86</b>  |  | 2b. HOUR<br><b>5:30 AM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>17</b> YEAR <b>01</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b><br>YRS. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4136 CLIFFVALE RD.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CARPENTER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BUILDING</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4136 CLIFFVALE RD. 21236</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>PARIS</b> MIDDLE <b>LAMBERT</b> LAST <b>LAMBERT</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LOUEMMA</b> MIDDLE <b>ODELL</b> LAST <b>ODELL</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-3059</b>   |  | 17. INFORMANT ADDRESS<br><b>ADA METTEN 348 ELMOR AVE BALTO 21236</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADVANCED Emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last                   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.<br><b>NONE</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-26-78</b> , 19 <b>86</b> , to <b>3-11</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>12-5</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Joel S. Kleinman, MD</b>   |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>3-12-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOEL S. Kleinman, MD</b>  |  |  |  | 22e. ADDRESS<br><b>9712 BELAIR Rd BALT 21236</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3/15/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SCHIMUNEK FUNERAL HOME INC.</b> ADDRESS <b>9705 BELAIR RD BALTO. MD. 21236</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |

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00-00681

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07009

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |                            |  |  |  |  |   |  |   |  |
|--|--|---|--|--|----------------------------|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MICHAEL John LANASA Sr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 17 '86</b> |  | 2b. HOUR<br><b>4:05A</b> M |  |  |  |  |   |  |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>cau</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 14 1916</b>  |                            | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                    |  | 8 IF UNDER 24 HRS<br>HOURS MIN.   |  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |  |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N.CHARLES ST.</b> |  |  |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |   |  |  |                            | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Essex</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  | 13e. STREET ADDRESS / ZIP CODE<br><b>166 Wiltshire Road 21221</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Lanasa</b>  |  |   |  |  |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Batz</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW11 213-07=4319</b>   |                            | 17. INFORMANT<br>ADDRESS<br><b>Ruth Lanasa 166 Wiltshire Rd. 21221</b>   |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>  |  |   |  |  |                            |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RESPIRATORY FAILURE</b>   |  |   |  |  |                            |  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |  |                            |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |   |  |  |                            |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                            |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1/14 86</b>  |                            |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>1/14 86</b>   |                            |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3/17 86</b>            |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/14 86</b> to <b>3/17 86</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/17 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                            |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>C. Hogge MD</b>   |  |   |  |  |                            | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/17/86</b>   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C.HOGGE</b>  |  |   |  |  |                            | 22e. ADDRESS<br><b>GBMC-6701 N.CHARLES ST.</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>3/19/86</b>  |                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>        |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>   |  |   |  |  |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Friedman-Randall</b>                    |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |   |  |   |  |                        | 8 6 0 7 0 1 0                                |  |
|---|--|---|--|---|---|--|---|--|------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.  |  |   |  |                        |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ANNA B. LANG   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/31/86  |  |   |  | 2b. HOUR<br>12:55 P.M. |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05-02-02  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS                                  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                        | 7b. IF UNDER 24 HRS<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>GERMANY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Germany   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.               |   |  |                        |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |                        |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE<br>108 S. Callender St., 21201              |   |  |                        |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Fritz Blochl  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary UNKNOWN   |  |   |  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-50-7405  |  | 17. INFORMANT ADDRESS<br>Joseph A. Lang, 2097 Montevideo Rd., 20794   |   |  |   |  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>S/P L Bx amputation</u>            |  |   |  |   |   |  |   |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |   |  |   |  |                        |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |  |   |  |                        |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |   | CITY OR TOWN   |   | COUNTY   |                        | STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. That (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |  |                        |  |  |
| 22b. SIGNATURE<br>Dr. Tomhe M.D.  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED   |                        |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Tomhe  |  |   |  |   | 22e. ADDRESS<br>St. Joseph Hospital   |  |   |  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4/3/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem.  |   | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore                                 |   | COUNTY<br>Maryland   |                        | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, Inc., 4107 Wilkens Ave.   |  |   |  |   | 25a. DATE RECEIVED BY REGISTRAR<br>APR 02 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall |  |                        |  |  |

BP



10-01070

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07011

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |   |   |  |
|--|--|---|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nancy G. LANNON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 20, 1986</b> |   | 2b. HOUR <sup>a</sup><br><b>10:45</b> M |   |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB. 11, 1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSEDALE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>                              |   | 13c. CITY OR TOWN<br><b>PARKVILLE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. GRUBB</b>   |  |   | 15. MOTHER'S NAME<br>FIRST MIDDLE LAST<br><b>Annie KYES</b>  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216 309 028</b>  |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>March 17 86</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>9000 Franklin Square Drive, 21237</b>   |   |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 17 86</b> , to <b>March 20 86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 20 86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) not view the body after death. |  |   |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Carlos J. Page</b>  |  |   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>3/20/86</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Carlos J. Page, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-24-1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD L.S.M.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MARYLAND</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHARLES OF MEMORIES HARFORD</b>   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>MAR 21 1986</b>  |   |   |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-01302

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove appropriate pages and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |               | REG. NO.<br>8607012  |  |
|---|--|--|---|---|---------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROSE M LAVEZZA   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 19 86 |   | 2b. HOUR<br>M |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 23 03  |               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST JOSEPH HOSPITAL |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER  |               | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |               |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>Parkville  |               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Frank  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Julia Rose  |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>216465596  |   | 17. INFORMANT ADDRESS<br>Miss Rita M. Lavezza Same as # 13e   |               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>45 minutes   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |   |   |               |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |               |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |               |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |   |   |               |  |  |
| 23a. SIGNATURE<br>David R. Brunswick MD   |  |  |   | DEGREE  |               | 23c. DATE SIGNED<br>3/19/86  |  |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID R. BRESWICK MD   |  |  |   | 23d. ADDRESS<br>ST JOSEPH HOSPITAL  |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3-22-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |               | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR NAME<br>Leonard J. Ruck, Inc.  |  |  |   | ADDRESS<br>Baltimore, Md.   |               | 25a. DATE REC'D. BY REGISTRAR<br>MAR 21 1986   |  |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br>In [Signature]  |               |  |  |

WHITE  
CALTO COUNTY  
USA

WHITE  
CALTO COUNTY  
USA

WHITE  
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WHITE  
CALTO COUNTY  
USA



00-00282

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 1 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY E. LAW</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 14, 1986</b> |  |  | 2b. HOUR<br><b>4:00 A.M.</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 14, 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CARNEY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9429 RIDGLEY AVE.</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BLACK+DECKER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>CARNEY</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>9429 RIDGLEY AVE. 21234</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL B. LAW</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EDITH RUSSELL</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>2A 222039</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Ischemia - Arteriosclerotic</b><br>DUE TO OR AS A CONSEQUENCE OF (b) <b>Cardiovascular disease</b><br>DUE TO OR AS A CONSEQUENCE OF (c) <b>Hypoxia - Compromised respiratory excursion</b><br>DUE TO OR AS A CONSEQUENCE OF (d) <b>Severe Osteo + Rheumatoid arthritis &amp; anemia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. — 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>—</b>   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— — — — —</b>  |  | 21g. I certify that (I) (this hospital) attended the deceased from <b>Mar 57</b> to <b>Mar 86</b> , that (I) (we) last saw the deceased alive on <b>3/6/86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) (and) (we) saw the body after death. |  |  |  |
| 21h. SIGNATURE<br><b>Frank T. Kasik, Jr.</b>   |  |   |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 21i. DATE SIGNED<br><b>3/14/86</b>   |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. FRANK T. KASIK, JR.</b>  |  |   |  | 22b. ADDRESS<br><b>9005 HARFORD ROAD - PARKVILLE</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>3-14-1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHESAUT GROVE</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SWEET AIR BALTO. MO.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES HARFORD RO. 8800</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>  |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and collectively filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ST. LOUIS, MO.

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FOR Items 16b 12a, 12b G 613  
 1- STATE REGISTRAR 3/21/86 CW  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 6 1 0 7 0 1 4

REG. NO.

|   |  |  |  |   |  |  |  |   |   |  |
|---|--|--|--|---|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Allan R. Lawrence   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>03-06-86                         |   |  | 2b HOUR<br>2:03 PM   |  |   |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>5 3 10   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Balto Co.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  |   |  | 12a USUAL OCCUPATION<br>(TYPE AND FOR HOW LONG (GIVE LIFE))<br>Auditor Retired   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>STATE  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.   |  |  | 13b COUNTY<br>Balto. Co.   |   | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS / ZIP CODE<br>1308 Brixton Rd. 21239 |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>David Lawrence   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lena Theil            |   |  |  |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1944-1962    |   | 17 INFORMANT<br>Mrs. A.R. Lawrence                       |  | ADDRESS<br>1308 Brixton Road 21239   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ADVANCED CARDIOVASCULAR ARTERIOSCLEROSIS</b>   |  |  |  |   |  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>POSSIBLE MYOCARDIAL INFARCTION- CONGESTIVE HEART FAILURE</b>   |  |  |  |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (do) (do not) view the body after death. |  |  |  |   |  |  |  |   |   |  |
| 22b. SIGNATURE<br>  |  |  | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3-7-86  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>REYNALDO ORJUELA-GOMEZ M.D.  |  |  | 22e. ADDRESS<br>St Joseph Hosp   |   |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>3-11-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Virginia                               |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Mitchell Wiedefeld   |  |  | ADDRESS<br>8500 York Road  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_

547-516

Exhibit - MacArthur Memorial - Confederate Heart Shrine

3-3-28



CREMATION PAR. 2, CO. CARROLL CREMATION HANSTEAD, MD.

ELINE FUNERAL HOME ELLISTONSTOWN, MD.

ABRAHAM

LEISTER

WORK

SPRINKLE

NO.

BALTIMORE

X

3411 HARVIEW AVE. 21234

RANDALLSTOWN BALTO. CO. GEN. ROBERT.

ETIRED CAB DRIVER

BALTO. CO. MD.

NO.

X

BALTIMORE CO.

MALE WHITE

SEPT. 1, 1902

BO

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 07016

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Myrtle Anna Letrise   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 30 1986                   |   |  | 2b. HOUR<br>9:45 AM  |   |  |  |
| 3 SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 18 01  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)<br>27 Bishops Lane |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |   |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Catonsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>27 Bishops Lane 21228  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herbert Gripp  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Myrtle Unknown   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>217-46-2690  |  | 17. INFORMANT<br>ADDRESS<br>21228 Joseph J. James 29 Bishops Lane   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A.S.H.D. &amp; Pulmonary Edema, A. fibrillator</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>long def. Anemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Years.</u><br><u>Years.</u> |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/1/1987</u> to <u>3/30/1986</u> that (I) (we) lost saw the deceased alive on <u>3/28/1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Dr. Adnan Sonmez</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4/1/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Adnan Sonmez  |  |  |  |   |  | 22e. ADDRESS<br>500 N. Rolling Road  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>04-02-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Baltimore City MD |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home, Catonsville, MD  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 2 1986  |   | 25b. REGISTRAR'S SIGNATURE   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   | REG. NO. |  |  |
|--|--|---|--|---|----------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>M. GRACE - LETSCHIN</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 16, 86</b>  |          | 2b. HOUR<br><b>1:15 A</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-9-1894</b>   |          | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hsop</b> |  |   |          | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>                                       |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |          | 13e. STREET ADDRESS / ZIP CODE<br><b>1660 E. Belvedere Ave 21239</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>- McGreevy</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Elizabeth Phillips</b>   |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-20-1805</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Robert E. Letschin Sr. Same</b>  |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>3 ophtic mia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>urinary tract infection and</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>De celerity ulcer.</b> |  |   |  |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |   |          |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |          |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1</b> , 19 <b>86</b> , to <b>March 16</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>March 16</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |          |  |  |
| 22b. SIGNATURE<br><b>Shassem Pourmotabbed, M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |          | 22c. DATE SIGNED<br><b>3-16-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GHASSEM POURMOTABBED</b>   |  |   |  | 22e. ADDRESS<br><b>Balt. Co. Gen. Hospital</b>  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF BY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar. 20, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1986</b>   |          | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |

Baltimore County

Widow of John J. ...

John J. ...

...

...

Baltimore

...

...

8 6 0 7 0 1 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DORA</b>  |  | FIRST<br><b>LIPSY</b>   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 23, 86</b>  |  | 2b. HOUR<br><b>1:25 P</b>  |  |  |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 7, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF EARNING LIFE)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |  |  |
| 13a. STATE OF RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS - ZIP CODE<br><b>7444 RICKSWAY RD. 21208</b>   |  |  |  |
| 14. FATHER'S NAME<br><b>JACOB</b> MIDDLE <b>SCHENKER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br><b>MINNIE</b> MIDDLE <b>UNKNOWN</b> LAST  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-4785D</b>   |  | 17. INFORMANT <b>MRS. MIGNON FREIMAN</b> ADDRESS<br><b>7444 RICKSWAY RD. BALTO., MD 21208</b>   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last         |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Diabetes mellitus</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                        |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 23, 1986</b> to <b>March 23, 1986</b> , that (I) (we) lost<br>saw the deceased alive on <b>March 23, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Sharon Pountalabed, M.D.</b>   |  |   |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-23-86</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GRASSEM POUNTALABED</b>   |  |   |  | 22e. ADDRESS<br><b>Balto. Co. Gen. Hospital</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MAR. 24, 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH HAMEDROSH HOBODOL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |   |  | ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO. MD 21215</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If when 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

01010-00

ARDEN G. LIVINGSTON

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

07019

1- FOR  
STATE  
REGISTRAR

ARDEN G.

REG. NO.

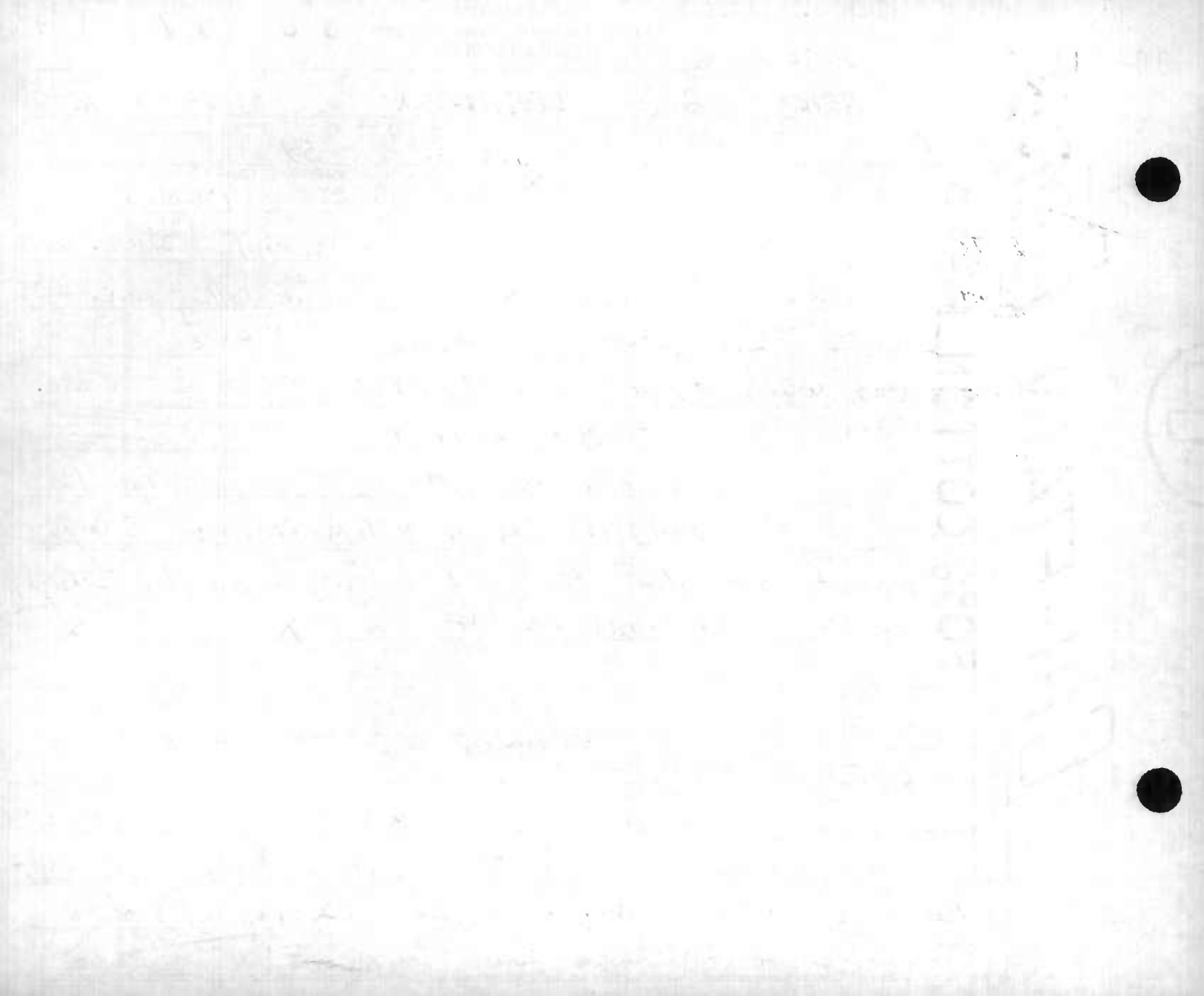
|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ARDEN G. LIVINGSTON   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03-27-86   |   | 2b. HOUR<br>1805M   |
| 3. SEX<br>MALE M   | 4. RACE<br>CAUCASIAN   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 25 26   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                    |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANIA   | 9. CITIZEN OF WHAT COUNTRY?<br>USA   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |   |
| 12. CITY OR TOWN OF DEATH<br>TOWSON  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SAINT JOSEPH Hospital |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>POLICEMAN                    |   | 15. KIND OF BUSINESS OR INDUSTRY<br>BALTO. CITY                 |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD.   |  | 13b. CITY OR TOWN<br>BALTO.  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13d. STREET ADDRESS / ZIP CODE<br>845 No. Collington Ave. 21205 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LIONEL Livingston  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna BAIR   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> WWII  |  | 16b. SOCIAL SECURITY NO.<br>199-14-2830  |   | 17. INFORMANT<br>ADDRESS<br>MARIE LIVINGSTON 845 COLLINGTON AVE.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>UNSTABLE ANGINA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>MULTIPLE ORGAN SYSTEMS FAILURE</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 month</u><br><u>5 Days</u> |  |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><u>Medicisthritis; Colonic Bleeding &amp; Necrosis; Gastric Bleeding; Renal Failure</u>  |  |  |   |   |   |
| 19a. DATE OF OPERATION<br>02-28-86   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>UNSTABLE ANGINA  |  | 20a. AUTO PSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>24 February 1986</u> to <u>27 MARCH 1986</u> , that (I) (we) last saw the deceased alive on <u>27 March 1986</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)  |  |  |   |   |   |
| 22b. SIGNATURE<br><u>Stephen Lincoln</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>         |   | 22c. DATE SIGNED<br>03-27-86  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stephen Lincoln MD.   |  | 22e. ADDRESS<br>7620 York Rd., Balto. County Md.   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>4-2-86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cem  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>James J. [unclear]</u>  |  | ADDRESS<br>1211 Clasco Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 01 1986  | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>     |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as any injury, or other traumatic event, the medical examiner must be notified.



00-01169

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07020

REG. NO.

|   |  |  |   |   |                    |  |  |
|---|--|--|---|---|--------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Stanley Joseph Longford   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3-22-86 |   | 2b. HOUR<br>7:50 P |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 21, 1917  |                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County Hospital  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Design Engineer  |                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>G.G. + E.   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>CARROLL   |   | 13c. CITY OR TOWN<br>Sykesville   |                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert Carroll Longford  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Beulah I. Hines  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes  |                    | 16b. SOCIAL SECURITY NO.<br>215 01 0244  |  |
| 17. INFORMANT ADDRESS<br>Frances Longford Sykesville, Md.   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF (b) EMPHYSEMA<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>BRONCHOPLEURAL FISTULA, EMPHYSEMA |   |   |                    |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                    |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                    |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3/14, 1986, to 3/22, 1986, that (I) (we) lost saw the deceased alive on 3/21/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |                    |  |  |
| 22b. SIGNATURE<br>Purnushottam Mitra  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                    | 22c. DATE SIGNED<br>3-22-86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PURUSHOTTAM MITRA  |  |  |   | 22e. ADDRESS  |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK IF)<br>Burial  |  | 23b. DATE<br>3-26-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |                    | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Harry W. Haight  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 24 1986  |                    | 25b. REGISTRAR'S SIGNATURE<br>John D. ...  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes, mostly illegible due to blurriness and bleed-through. Some legible fragments include:

- Top left: "3 - 7-21"
- Top center: "Judy Lee Ford"
- Top right: "Baltimore County"
- Middle left: "Baltimore County"
- Middle center: "Judy Lee Ford"
- Middle right: "Baltimore County"
- Bottom left: "Baltimore County"
- Bottom center: "Judy Lee Ford"
- Bottom right: "Baltimore County"

Handwritten notes at the bottom of the page, mostly illegible. Some legible fragments include:

- Bottom left: "Baltimore County"
- Bottom center: "Judy Lee Ford"
- Bottom right: "Baltimore County"



00-02308

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 2 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Clara LORT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 27, 1986</b> |  |  | 2b. HOUR<br><b>11:40p<sub>M</sub></b>   |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-7-1903</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Ind.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                              |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rosedale</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Wrepper</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Super Bot Co.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Ind.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>601 Scott St. 21230</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Winkler</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara Boyd</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Stable Connolly 601 Scott St. 21230</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Intestinal Obstruction; Acute Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (X) this hospital attended the deceased from <b>March 6</b> 19 <b>86</b> to <b>March 27</b> 19 <b>86</b> , that (X) (we) last saw the deceased alive on <b>March 27</b> 19 <b>86</b> and that (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did not view the body after death.   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Hail</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>3-27-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Adam Fall, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-31-1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shalom Park Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Ind.</b>                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John J. Curran &amp; Son Inc</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>Mar 31 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rodden</b>                                       |  |  |  |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. (IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

UNITED STATES POSTAGE  
OFFICE OF THE POSTMASTER GENERAL  
WASHINGTON, D.C.

100-100000



00-02089

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 2 2

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |                              |  |   |  |  |
|--|--|--|---|---|------------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Frederick Earl Loudon   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 28, 1986                             |   |                              | 2b. HOUR<br>3:00A <sub>M</sub>   |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 8 1915  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2816 Yorkway Apt. C / 21222 |   |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Mfg.                    |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Dundalk |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick R. Loudon  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amelia Rode                  |   |                              | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |   |  |  |
| 16b. SOCIAL SECURITY NO.<br>213/09/1132  |  |  | 17. INFORMANT<br>ADDRESS<br>21222<br>Diane C. Jones 46 Portship Rd./Balto/Md. |   |                              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>AS CVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>18</u> |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CVA &amp; DIABETES mellitus</u>  |  |  |   |   |                              |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                              |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 67</u> to <u>3-28 19 86</u> that (I) (we) lost<br>saw the deceased alive on <u>3-24 19 86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) did (did not) view the body after death. |  |  |   |   |                              |  |   |  |  |
| 22b. SIGNATURE<br><u>Dr. Wyman Wong</u>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                              |  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Wyman Wong  |  |  |   | 22e. ADDRESS<br>6730 Holabird Ave. Balto., Md. 21222  |                              |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/31/1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland 21224  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley Inc. ADDRESS<br>Balto., Md. 21222  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 01 1986  |                              | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |  |  |

100-02082

43517 MULTICOX 3000

WATER MARK



00-00201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 6 0 7 0 2 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anna M LYNCH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 12, 1986</b>           |   |   | 2b. HOUR<br><b>12:05A<sub>M</sub></b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/30/1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rosedale</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3301 Leverton Ave.-21224</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick C. Stock</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen --- Challner</b>  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>---</b>   |  | 17. INFORMANT <b>Baltimore, Md. 21206</b><br><b>Mrs. Ellen M. Butta-5619 Gardenville Ave.</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>   |  |   |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 14, 19 86</b> , to <b>March 12, 19 86</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 12, 19 86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>R. Woodward MD</b>  |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-12-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. Woodward, M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/14/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery- Baltimore, Md.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John A. Moran, Inc. Funeral Home</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. Moran</b>   |  |
| 26. ADDRESS<br><b>3000 E. Baltimore St.; Balto., Md. 21224</b>   |  |   |  |   |   |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, the medical examiner must be notified.

BP

EXCEL NOTED 203

MAY 19 1967

|        |       |          |   |           |           |
|--------|-------|----------|---|-----------|-----------|
| Female | White | U. S. A. | X | Housewife | Housewife |
| Male   | White | U. S. A. | X | Housewife | Housewife |

|           |          |          |   |           |           |
|-----------|----------|----------|---|-----------|-----------|
| Frederick | E. Stock | U. S. A. | X | Housewife | Housewife |
| Frederick | E. Stock | U. S. A. | X | Housewife | Housewife |

John A. Kohn, Inc. Funeral Home  
 3100 E. Baltimore St. Baltimore, Md. 21224

00-01360

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN ALIBY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |   |                                     |
|--|-------------------------|---|-------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNE R LYSTON</b>   |                         | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR     |                                     |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>Feb</b> DAY <b>6</b> YEAR <b>1903</b>  | 6. AGE (IN YEARS)<br>YRS. <b>83</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 10. CITY OR TOWN OF DEATH<br><b>Baynesville</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8523 Water Oak Rd. (Residence)</b> |                                     |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |                                     |
| 14. FATHER'S NAME<br>FIRST <b>Richard</b> MIDDLE <b>Feder</b> LAST <b>Feder</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Pauline</b> MIDDLE <b>Thon</b> LAST <b>Thon</b>  |                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>214-40-3013</b>  |                                     |
| 17. INFORMANT<br><b>John R. Lyston</b>   |                         | ADDRESS<br><b>8523 Water Oak Rd. 21234</b>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br><b>PLASTIC BAG OVER HEAD</b><br>(b) <b>PLASTIC BAG OVER HEAD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>!</b> |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |                                     |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                     |
| 20a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |                                     |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                     |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                         | 22b. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b>Maryland</b>   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |                         | 23b. DATE<br><b>3-26-1986</b>   |                                     |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Maryland</b>   |                         | 25a. DATE REC'D BY REGISTRAR <b>MAR 26 1986</b>   |                                     |
| 25b. REGISTRAR'S SIGNATURE <b>Paul F. Guerin</b>   |                         | DATE SIGNED <b>3/23/86</b>  |                                     |



CONFIDENTIAL

1963

U.S.A.

SECRET

CONFIDENTIAL

1. The purpose of this document is to provide information regarding the activities of the [redacted] in the [redacted] area. The information is classified as [redacted] and is to be controlled in accordance with the [redacted] policy.

2. The information is to be controlled in accordance with the [redacted] policy. The information is to be controlled in accordance with the [redacted] policy.

3. The information is to be controlled in accordance with the [redacted] policy. The information is to be controlled in accordance with the [redacted] policy.

4. The information is to be controlled in accordance with the [redacted] policy. The information is to be controlled in accordance with the [redacted] policy.

5. The information is to be controlled in accordance with the [redacted] policy. The information is to be controlled in accordance with the [redacted] policy.

6. The information is to be controlled in accordance with the [redacted] policy. The information is to be controlled in accordance with the [redacted] policy.

7. The information is to be controlled in accordance with the [redacted] policy. The information is to be controlled in accordance with the [redacted] policy.

8. The information is to be controlled in accordance with the [redacted] policy. The information is to be controlled in accordance with the [redacted] policy.



00 - 00644

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 2 5

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |  |
|---|--|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Premen Edward Macciola</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 16, 1986</b> |   | 2b. HOUR<br><b>1:00PM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 31, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b><br>YRS MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cabinet Maker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Baltimore Middle River</b>  |  |   |  |   |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel Macciola</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Bruno</b>   |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-07-9445A</b>                                      |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Thelma R. Macciola same as 13c</b>  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| MEDICAL CERTIFICATION   |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>March 14, 1986</b> to <b>March 16, 1986</b> , that I (we) last saw the deceased alive on <b>March 16, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Vincent Morgan, MD.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>3/16/86</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Vincent Morgan, MD</b>  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-20-1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1986</b>   |  |  |   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00000-00106

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07026  
REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |                         |  |   |  |   |  |   |  |  |  |   |  |                                   |  |  |  |  |  |
|--|--|-------------------------|--|---|--|---|--|---|--|--|--|---|--|-----------------------------------|--|--|--|--|--|
| DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><b>ROBERT</b>  |  | MIDDLE<br><b>E.</b>   |  | LAST<br><b>MADIGAN</b>                                |  | 2a. DATE KNOWN OF DEATH   |  | MONTH<br><b>3</b>                                      |  | DAY<br><b>9</b>   |  | YEAR<br><b>1986</b>               |  | 2b. HOUR<br><b>9<sup>00</sup></b>                |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH<br><b>11</b> DAY<br><b>08</b> YEAR<br><b>03</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>82</b> YRS.  |  | IF UNDER 1 YR.<br>MONTHS<br><b>0</b> DAYS<br><b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> MIN.<br><b>0</b> |  | 7c. DATE PRONOUNCED DEAD<br><b>3</b> MONTH<br><b>9</b> DAY<br><b>1986</b>           |  | 2d. HOUR<br><b>9<sup>00</sup></b> |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto COUNTY</b>                         |  |                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Reisterstown</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GARRISON VALLEY N.H.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Crane Operator</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>                             |  |                                   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. CITY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>7365 Edsworth Road</b>       |  |   |  | 21222                             |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST<br><b>Frank</b>   |  |                         |  | MIDDLE<br><b>Madigan</b>  |  | LAST<br><b>Ella</b>                                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>Ella</b>  |  |  |  | MIDDLE<br><b>Eagan</b>  |  | LAST<br><b>Eagan</b>              |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-7000</b>        |  | 17. INFORMANT<br><b>Carolyn Sofinowski</b>  |  |  |  | ADDRESS<br><b>Same as 13e</b>   |  |                                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIAATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>SUICIDE BY LIGATURE (HANGING)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 minutes</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                         |  |   |  |   |  |   |  |  |  |   |  |                                   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.  |  |                         |  |   |  |   |  |   |  |  |  |   |  |                                   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |   |  |                                   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |  |  |   |  |                                   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .       |  |                         |  |   |  |   |  |   |  |  |  |   |  |                                   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John R. Steinberg</b>   |  |                         |  | TITLE (SPECIFY)<br><b>DEPUTY</b>  |  |   |  | M.D. <b>DEPUTY</b> MEDICAL EXAMINER   |  |  |  | DATE SIGNED<br><b>3/9/86</b>  |  |                                   |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>JOHN R. STEINBERG</b>   |  |                         |  | ADDRESS<br><b>7 TENTMILL LA, Apt L 21208</b>  |  |   |  |   |  |  |  |   |  |                                   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>3/12/1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b> |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>      |  |   |  | COUNTY<br><b>Maryland</b>         |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>   |  |                         |  |   |  |   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1986</b>                                 |  |                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |  |  |
| 7922 Wise Avenue Dundalk, Maryland 21222   |  |                         |  |   |  |   |  |   |  |  |  |   |  |                                   |  |  |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]

Re New York letter to Bureau dated 1/15/54.  
Enclosed for the Bureau are two copies of a letterhead memorandum dated 1/15/54.



The letterhead memorandum is being furnished to the Bureau for information.  
Very truly yours,  
[Illegible Signature]

Enclosure  
[Illegible]

00-02042

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 2 7

REG. NO.

|  |   |  |  |   |   |
|--|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Mary Paulissa Mafera</i>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>March 19 1986</i>  |  | 2b. HOUR<br><i>4 20 AM</i>  |   |
| 3 SEX<br><i>Female</i>   | 4 RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>03 06 95</i>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>91</i>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.Y.</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                              |   |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>St. Joseph Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Nurse Teacher</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Religious</i> |
| 13a. STATE<br><i>Maryland</i>  |   | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Stanislaus Mafera</i>  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Amtman</i>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>220-54-2948A</i>   |  | 17 INFORMANT<br>ADDRESS<br><i>Sr. M. Angelina 6401 N. Charles St. 21212</i>                     |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____               |   |  |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><i>Coronary Heart Disease, Congestive Heart Failure and Renal Insufficiency</i>  |   |  |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/15</i> , 19 <i>86</i> , to <i>3/19</i> , 19 <i>86</i> , that (we) last saw the deceased alive on <i>3/19</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |  |  |   |   |
| 22b. SIGNATURE<br><i>Lester A. Wall Jr MD</i>  |   |  |  | 22c. DATE SIGNED<br><i>3/19/86</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>LESTER A. WALL JR MD</i>   |   |  |  | 22e. ADDRESS<br><i>7620 York Rd Towson MD 21204</i>   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |   | 23b. DATE<br><i>3-21-86</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Villa Maria</i>  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>Mitchell-Wiedefeld Home</i>  |   | ADDRESS<br><i>6500 York Road 21212</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 26 1986</i>   |   |
|  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Gula Davidson-Randall</i>                                      |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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072051

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07028

|   |  |   |  |   |  |  |   |   |   |
|---|--|---|--|---|--|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Noreine V. MAGSAMEN  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 5, 1986                   |   |  | 2b. HOUR<br>4:15a M  |   |   |   |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 12 17  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |
| 2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaking   |   |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br>203 Riverton Rd. Balto. Md. 21220 |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Robertson   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elsie Sterling   |  |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>216-01-3728   |  | 17. INFORMANT<br>ADDRESS 10521 Saddlebrook<br>Mrs. Marlene V. Forster Ct.-Laurel, Md. 20707   |  |  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Acute Renal Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION   |  |   |  |   |  |  |   |   |   |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |   |
| 22a. I certify that (this hospital) attended the deceased from <u>February 7, 1986</u> , to <u>March 5, 1986</u> , that (we) last<br>saw the deceased alive on <u>March 5, 1986</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |   |   |
| 22b. SIGNATURE<br><u>Richard Beninegna</u> MD   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>03/05/86  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Beninegna, M.D.  |  |   |  |   | 22e. ADDRESS<br>9000 Franklin Sq. Dr., 21237   |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial   |  |   | 23b. DATE<br>3-7-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>07/1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson</u>                  |   |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





0-02380

1- FOR  
STATE  
REGISTERSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 0 7 0 2 9

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) J. Eleanor Malcolm   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR 3 30 86   |  | 2b. HOUR 12 45 AM   |  |
| 3. SEX Female  |  | 4. RACE White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR Oct. 24 1910   |  |
| 7a. BIRTHPLACE<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                           |  |
| 10. CITY OR TOWN OF DEATH Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland  |  | 13b. COUNTY Baltimore   |  | 13c. CITY OR TOWN Cockeysville  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST Arthur McHenry Maddux   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST Sarah Ella Langville  |  | 12b. KIND OF BUSINESS OR INDUSTRY Office Mgr. / Retail Mfg.   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 215-16-2250  |  | 17. INFORMANT ADDRESS Donald E. Bowman, 4253 W. Rivers Edge   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) arterio sclerotic cardio vascular disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal failure                       |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  |   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 6, 1986, to March 30, 1986, that (I) (we) last saw the deceased alive on March 28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br>K R Faulkner MD  |  | 22c. DATE SIGNED<br>March 30, 1986  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kendall R. Faulkner MD   |  |
| 22e. ADDRESS<br>Stella Maris   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22g. DATE SIGNED<br>March 30, 1986  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 4/2/86  |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE Pikesville Baltimore Md.  |  | 23e. DATE REC'D. BY REGISTRAR   |  | 23f. REGISTRAR'S SIGNATURE  |  |
| 24. FUNERAL DIRECTOR<br>NAME Martin D. Lawson, 10 W. Padonia Rd. 21093   |  | 24b. DATE REC'D. BY REGISTRAR   |  | 24c. REGISTRAR'S SIGNATURE  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0-0520



063044

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 3 0

REG. NO.

|  |                              |   |                                  |  |   |  |  |   |
|--|------------------------------|---|----------------------------------|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              |   | 2a. DATE OF DEATH                |  |   | 2b. HOUR                                   |  |   |
| FIRST MARY MIDDLE Catherine LAST MANGER  |                              |   | MONTH 3 DAY 5 YEAR 86            |  |   | 2:30 P.M.                                  |  |   |
| 1. SEX   | 4. RACE                      | 5. DATE OF BIRTH  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR                            |  | IF UNDER 24 HRS.                                |
| female   | caucasian                    | MONTH 5 DAY 11 YEAR 1892  |                                  | 93 YRS   |   | MONTHS DAYS                                |  | HOURS MIN.                                      |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |   |
| Maryland   | U.S.A.                       |   |                                  | Balto. County MD.  |   |  |  |   |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |                                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |
| Randallstown   |                              | Chapel Hill Comm. Home  |                                  |  | Cafeteria Work  |  | Hospital   |   |
| 13a. STATE   |                              |   | 13b. COUNTY                      | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |   |
| md.  |                              |   | Balto.                           | Upperco  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 5303 Emory Rd 21155  |   |
| 14. FATHER'S NAME  |                              |   | 15. MOTHER'S MAIDEN NAME         |  |   |  |  |   |
| FIRST MIDDLE LAST Thomas Bivens  |                              |   | FIRST MIDDLE LAST Elizabeth Hull |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)  |                              |   | 16b. SOCIAL SECURITY NO.         |  | 17. INFORMANT ADDRESS   |  |  |   |
| No   |                              |   | 217-24-2699                      |  | Doris C. Armacost 5303 Emory Rd Upperco, md.                        |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:   |                              |   |                                  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Aortic Aneurysm Rupture  |                              |   |                                  |  |   |  |  | 10 yrs  |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD   |                              |   |                                  |  |   |  |  | 20 yrs  |
| DUE TO, OR AS A CONSEQUENCE OF (c) COPD & IV   |                              |   |                                  |  |   |  |  | 5 yrs.  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                              |   |                                  |  |   |  |  |   |
| Cardiac Arrhythmias  |                              |   |                                  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |
| none   |                              | none  |                                  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |   |
|  |                              | P.M. 19   |                                  |  |   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |   |
|  |                              |   |                                  |  |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/24 1985 to 3/5 1986 that (I) (we) last saw the deceased alive on 3/5 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |                              |   |                                  |  |   |  |  |   |
| 22b. SIGNATURE OF  |                              |   |                                  | 22c. DATE SIGNED   |   |  |  |   |
| Martin J. Feldman  |                              |   |                                  | 3/6/86   |   |  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                              |   |                                  | 22e. ADDRESS   |   |  |  |   |
| Martin J. Feldman  |                              |   |                                  | 1 E. Cherry Hill Rd Rest. 21136  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |                              | 23b. DATE   |                                  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |
| Burial   |                              | Mar. 8, 1986  |                                  | Stone Chapel Cem.  |   | P. Kesville Balto. md.                     |  |   |
| 24. FUNERAL DIRECTOR   |                              |   |                                  | 25. DATE REC'D BY REGISTRAR  |   |  |  |   |
| N. J. Eshbult  |                              |   |                                  | MAR 8 1986   |   |  |  |   |
| ADDRESS  |                              |   |                                  |  |   |  |  |   |
| Owings Mills, md   |                              |   |                                  |  |   |  |  |   |

[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page. Some words like "Selling" and "170000" are visible.]

00-00669

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5835.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 7 0 3 1

REG. NO.

|  |  |   |   |   |   |  |   |  |   |  |
|--|--|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME -<br>(TYPE OR PRINT) <b>William H Marshall, JR.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-18-86</b>                         |   |   | 2b. HOUR<br><b>1454</b> M  |   |  |   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-9-14</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AAI</b>  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>21204</b>                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1608 MUSSULA RD. 21204</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM H. MARSHALL, SR.</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY ELIZABETH MCCUEN</b> |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>-----</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>0. NANCY MARSHALL 1608 MUSSULA RD. 21204</b>   |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b>   |  |   |   |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |   |   |   |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |   |   |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>GI BLEEDING</b>   |  |   |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)             |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>86</b> , to <b>3/18</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>David Klassen</b>   |  |   | DEGREE  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>3/18/86</b>                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID KLASSEN</b>  |  |   | 22e. ADDRESS<br><b>ST. JOSEPH HOSPITAL</b>                                    |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>MARCH 20, '86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEMETERY</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MARYLAND</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>  |  |   | ADDRESS<br><b>8521 LOCH RAVEN BLVD.</b>                                       |   |   | 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 19 1986</b>  |   |  |   |  |

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Page 1



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 3 2

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE S MARTIN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 3 86</b>  |  | 2b. HOUR<br>M<br><b>AM</b>   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 11 01</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic-Service</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mgr.</b>   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   | 13c. CITY OR TOWN<br><b>TOWSON</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS / ZIP CODE<br><b>1654 ABERDEEN RD 21204</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Martin</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Smith</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-05-6733</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Catherine Martin - Same as #13e</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiomyopathy + Congestive Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized debilitation 2nd to Pancreatic Carcinoma with metastasis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING? <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 11 86</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>9005 Harford Rd., Parkville, Md. 21234</b>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 2 1986</b> to <b>Mar 3 1986</b> that (I) (we) lost<br>saw the deceased alive on <b>Mar 2 1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Frank T. Kasik, Jr.</b>   |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/><br>DATE SIGNED<br><b>3/4/86</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Frank T. Kasik, Jr.</b>  |  | 22e. ADDRESS<br><b>9005 Harford Rd., Parkville, Md. 21234</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-6-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto., Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1986</b>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | Last First Middle  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| MARTIN   |  | WILLIAM E.   |  | 3-5-86   |  |
| 3. SEX Male  |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |
| M.   |  | W.   |  | 11 04 11   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Md.  |  | U.S.A.   |  | 74 YRS   |  |
| 8. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Catonsville  |  | Tawes/Bland Bryant Nursing Home  |  | Baltimore Co. MD.  |  |
| 10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Maryland   |  | Baltimore  |  | 416 Tuxedo St., Balto. Md. 21211   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)          |  |
| Unk. Carlin M Martin   |  | Unk. Esther Lurene   |  | 16b. SOCIAL SECURITY NO.   |  |
| 2. 16c. STREET ADDRESS / ZIP CODE  |  | 17. INFORMANT ADDRESS  |  | 220-07-0055  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)   |  | 19. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| PART I. DEATH WAS CAUSED BY:   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |
| (b) Aspiration Pneumonia   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK |  |
| DUE TO, OR AS A CONSEQUENCE OF:  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| (c) OBS - Feeding N.G. tube  |  | 22a. I certify that (I) (this hospital) attended the deceased from 4-1-1981 to 3-5-1986, that (I/we) last saw the deceased alive on 3-5-1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. |  | 22b. SIGNATURE DEGREE  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |
| Perforated Diverticuli - Cholecystitis - Recurrent Aspiration  |  | 3-5-86   |  | CESAR VALLE CAVERO   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | 3-7-85   |  | Meadowridge Mem  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR SIGNATURE   |  |
| MacNabb Funeral Home, Catonsville, MD  |  | MAR 7 1986   |  | [Signature]  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 6 0 7 0 3 4  |  |  |   |
|---|--|--|--|--|--|--|---|
| FOR<br>STATE<br>REGISTRAR   |  |  |  | REG. NO.   |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>DANIEL</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 18 1986</b>   |  |  |   |
| 3. SEX<br><b>MALE</b>   |  |  |  | 2b. HOUR<br><b>9:35<sup>A</sup></b> M  |  |  |   |
| 4. RACE<br><b>BLACK</b>   |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 26 1922</b>  |  |  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS  |  |  |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.   |  |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |   |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER</b> |  |  |   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |
| 13a. STATE<br><b>D. C.</b>  |  |  |  | 13b. COUNTY<br><b>WASHINGTON</b>   |  |  |   |
| 13c. CITY OR TOWN<br><b>WASHINGTON</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |  |   |
| 13e. STREET ADDRESS / ZIP CODE<br><b>912 SHEPHERD STREET, N.W. 99999</b>  |  |  |  |  |  |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>GEORGE McALLISTER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>DORA WATSON</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>137 14 8891</b>   |  |  |   |
| 16c. WWI  |  |  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Tommie Grillo/sister/2700 Hamlin St.N.E. CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>              |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RENAL FAILURE, ANEMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>DIABETES MELLITUS; BILATERAL AMPUTEE WITH STUMP ULCER</b> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MIN.</b><br><b>YRS.</b><br><b>YRS.</b> |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 18</b> , 19 <b>85</b> , to <b>MARCH 18</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>MARCH 18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Vadhana C. Claud</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED <b>1986</b><br><b>MARCH 18,</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VADHANA C. CLAUD, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-24-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Quantico National</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Triangle, Va</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>John T. Rhines Co., 3015 12th St. N.E., D.C. 20017</b>   |  |  |  | 25a. DATE OF DEATH<br><b>MAR 21 1986</b>   |  |  |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                     |   |  |  |  |  |  |
|--|--|---|--|---|---------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JESSIE Keith MCBEE  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03 04 '86 |   | 2b. HOUR<br>6:30A M |   |  |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 12 1900  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |  |   |                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Florida   |  | 13b. COUNTY<br>Palm Beach   |  | 13c. CITY OR TOWN<br>Del Ray  |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>508 Rye Lane / 33444   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jesse E. Keith   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kate Berger  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |                     | 16b. SOCIAL SECURITY NO.<br>213/03/2884   |  | 17. INFORMANT<br>Keith W. McBe 1207 Berwick Rd. Ruxton, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |                     |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 WEEK |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |                     |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)  |                     |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY OFFICE FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                     |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26, 19 86, to 3/4, 19 86, that (I) (we) last saw the deceased alive on 3/4, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |                     |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Alan R. Malouf   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                     |   |  | 22c. DATE SIGNED<br>3/4/86   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALAN MALOUF, M.D.   |  |   |  | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES ST 21204   |                     |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>3/5/1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory   |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley Inc. Balto., Md. 21222   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1986   |                     | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages printed 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 was any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Helen Viola McCARTER</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 24, 1986</b>   |  |
| 3 SEX<br><b>Female</b>  |  | 2b. HOUR<br><b>5:45a</b> M   |  |
| 4 RACE<br><b>White</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 1 DAY 1908<sup>R</sup></b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SLEEPING FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |
| 12a. USUAL OCCUPATION<br>(1. USUAL OCCUPATION OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  |
| 13c. CITY OR TOWN<br><b>Essex</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Lovell</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Effie Eyler</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-24-2718</b>   |  |
| 17. INFORMANT<br>ADDRESS<br><b>George McCarter 9512 Horn Ave. 21236</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>End Stage Renal Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiovascular Disease</b>                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>March 22, 1986</b> , to <b>March 24, 1986</b> , that (we) last saw the deceased alive on <b>March 24, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Soehle</b>   |  | DEGREE<br><b>M.D.</b>  |  |
| 22c. DATE SIGNED<br><b>3/24/86</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GORTHERT</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Sq. Dr., 21237</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/27/86</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>  |  |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson</b>  |  |

BP

THE  
OFFICE OF THE  
ATTORNEY GENERAL  
WASHINGTON, D. C.



072041

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

07037

REG. NO.

|   |  |  |  |   |  |  |  |   |  |   |  |                     |  |
|---|--|--|--|---|--|--|--|---|--|---|--|---------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Mark   |  | MIDDLE<br>McClernan  |  | LAST<br>McClernan   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/8/86 |  | 2b. HOUR<br>3:42 PM |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 15 1957  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>28 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                     |  | 7b. IF UNDER 72 HRS<br>HOURS MIN.             |  |                     |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Florida  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |   |  |   |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Project Mgr.  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Contractors  |  |   |  |   |  |                     |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Reisterstown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS & ZIP CODE<br>12608 Sagamore Forest Lane<br>21136 |  |   |  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Leo Marvin McClernan  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Joan Agnes Brown  |  |   |  |  |  |   |  |   |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-72-7735   |  | 17. INFORMANT<br>Joan B. McClernan, 1810 Monkton Rd.,<br>21111  |  |  |  |   |  |   |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) POSSIBLE ANOXIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) OPEN HEART SURGERY<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |   |  |   |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br>OPEN HEART SURGERY FOR REPLACEMENT OF DEFECTIVE AORTIC MITRAL VALVES  |  |  |  |   |  |  |  |   |  |   |  |                     |  |
| 19a. DATE OF OPERATION<br>3-8-86  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>DEFECTIVE AORTIC VALVE PROSTHESIS<br>DEFECTIVE MITRAL VALVE                    |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |   |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |   |  |                     |  |
| 22a. I certify that (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |   |  |                     |  |
| 22b. SIGNATURE<br>REYNALDO RUIZ GOMEZ M.D.  |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>3-9-86   |  |   |  |   |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>REYNALDO RUIZ GOMEZ M.D.   |  | 22e. ADDRESS   |  |   |  |  |  |   |  |   |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/11/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. James Epis. Ch. Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Monkton Balto. Md.   |  |   |  |   |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Martin D. Lawson  |  | 25a. DATE RECD. BY REGISTRAR<br>MAR 11 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |   |  |   |  |                     |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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VENTILATION

POSITIVE PRESSURE

STANDARD

STANDARD

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3-8-42

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00-01632

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |         |  |        |   |                         |   |                  |                           |                          |          |
|--|---------|--|--------|---|-------------------------|---|------------------|---------------------------|--------------------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  | MIDDLE | LAST  | 2a. DATE KNOWN OF DEATH |   | MONTH            | DAY                       | YEAR                     | 2b. HOUR |
| JOSEPH DON MCCLURE   |         |  |        |   | March 23, 86            |   |                  |                           |                          | 7:47     |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS)   | IF UNDER 1 YR.          |   | IF UNDER 24 HRS. |                           | 7c. DATE PRONOUNCED DEAD |          |
| MALE   | WHITE   | 09 7 27 58 YRS.  |        |   |                         |   |                  |                           | March 23, 86             |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                  |                           |                          |          |
| usa, Maryland  |         | usa  |        | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |                         | Baltimore County, MD.   |                  |                           |                          |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |        | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                         |                         | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                  |                           |                          |          |
| TOWSON   |         | ST JOSEPH'S HOSPITAL                                     |        | Salesman  |                         | Maintenance Supplies  |                  |                           |                          |          |
| 13a. STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN   |                         | 13d. INSIDE CITY LIMITS?  |                  | 13e. STREET ADDRESS       |                          |          |
| MD   |         | Baltimore  |        | Parkton   |                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  | 20830 OLD YORK RD PARKTON |                          | 21120    |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |                         | 16b. SOCIAL SECURITY NO.  |                  | 17. INFORMANT             |                          |          |
| Joseph Hobert  |         | McClure  |        | Dema  |                         | Ray   |                  | Greer                     |                          |          |
| 16a. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/>   |         | 16b. WWII  |        | 205-22-3626   |                         | Norma L. McClure, Parkton, MD                                       |                  | 21120                     |                          |          |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> Sudden   |         |  |        |   |                         |   |                  |                           |                          |          |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>ASCD with Coronary Insufficiency</u> 6+ Moos  |         |  |        |   |                         |   |                  |                           |                          |          |
| (c)  |         |  |        |   |                         |   |                  |                           |                          |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |        |   |                         |   |                  |                           |                          |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |        |   |                         | 20. AUTOPSY?  |                  |                           |                          |          |
|  |         |  |        |   |                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |                           |                          |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY                                      |        | 21c. HOW INJURY OCCURRED  |                         | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |                  |                           |                          |          |
|  |         | HOUR A.M. MONTH DAY YEAR                                 |        |   |                         |   |                  |                           |                          |          |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY                                     |        | 21f. LOCATION   |                         |   |                  |                           |                          |          |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |         | (AT HOME, STREET, FACTORY, FARM, ETC.)                   |        | STREET  |                         | CITY OR TOWN COUNTY STATE   |                  |                           |                          |          |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |  |        |   |                         |   |                  |                           |                          |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |        |   |                         |   |                  |                           |                          |          |
| ACTUAL SIGNATURE   |         | MEDICAL EXAMINER   |        |   |                         | DATE SIGNED   |                  |                           |                          |          |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |        |   |                         |   |                  |                           |                          |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                         | 23d. LOCATION   |                  | COUNTY STATE              |                          |          |
| Burial   |         | Mar. 26, 1986  |        | West Liberty Cem.   |                         | White Hall, Balt., MD   |                  |                           |                          |          |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR                            |        | 25b. REGISTRAR'S SIGNATURE  |                         |   |                  |                           |                          |          |
| J.J. Hartenstein, New Freedom, PA 17349  |         | MAR 31 1986  |        | June Carson-Hopkins   |                         |   |                  |                           |                          |          |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

March 30 1914  
March 30 1914

RECEIVED

PAID BY BANK

Handwritten signature  
Handwritten signature

Handwritten signature

6/10/14

00-01304

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 3 9

REG. NO.

|   |  |  |   |   |  |   |
|---|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Marie L. McCormick</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 20 86</i> |   | 2b. HOUR<br>MIN.<br><i>10:45</i>   |   |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>May 16, 1889</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><i>96</i>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                             |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Valley View Nursing Home</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Clerk</i> |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Peter Stein</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Caroline Blomeier</i>  |   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>212-24-8690</i>   |   | 17. INFORMANT<br>ADDRESS<br><i>Dorothea M. Gauss 9502 Buckhorn Rd. 21234</i>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>ASCVD - CHF - ac Pulmonary edema</i><br>DUE TO, OR AS A CONSEQUENCE OF<br><i>Senile Dementia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br><i>alzheimer type</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 7/31 1985</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1, OR PART 2)   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (1) this hospital attended the deceased from <i>3/19 1986</i> to <i>3/20 1986</i> and that in my <i>best</i> opinion death occurred on the date and hour and from the causes stated above. (If true) (did not view the body after death)  |  |  |   |   |  |   |
| 22b. SIGNATURE<br><i>Donald W. M. M.D. ZEPH</i>   |  | DEGREE<br><i>M.D.</i>  |   | 22c. DATE SIGNED<br><i>3/28/86</i>  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DONALD W. M. M.D. ZEPH</i>  |  | 22e. ADDRESS<br><i>3009 EVERGREEN AVE BALTIMORE MD</i>   |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPY #)<br><i>Cremation</i>  |  | 23b. DATE<br><i>3/21/1986</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview Mem. Pk.</i>  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Leonard J. Ruck, Inc. Baltimore, MD</i>  |  | ADDRESS<br><i>21214</i>  |   | 25a. DATE REC'D BY REGISTRAR<br><i>MAR 21 1986</i>  |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Indell</i>   |  |  |   |   |  |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use on the burial-transit permit. Then please remove these pages. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
MAY 11, 1962  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK (100-157141)  
SUBJECT: [Illegible]  
RE: [Illegible]



[Illegible handwritten notes and stamps]

00-003734

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 07040  
REG. NO.

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joddie D McCready</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-10-86</b>  |  | 2b. HOUR<br><b>5:25pm</b>  |   |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 18, 1899</b>   |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.   |   |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |
| 12. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Joseph Hospital</b> |  | 14. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county</b> MD.   |   |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br><b>MARYLAND</b>   |  | 15b. COUNTY<br><b>BALTIMORE</b>  |  | 15c. CITY OR TOWN<br><b>BALTIMORE</b>  |   |
| 16. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH</b>  |  | 17. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CAROLINE DRUMMOND</b>  |  | 18. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 20. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.II 227 105192A</b>  |  | 21. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>PERFORATION, SIGMOID COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DIVERTICULOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Acute subendocardial myocardial infarction</b>  |  |  |  |  |   |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  | 20a. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2-27</b> , 19 <b>86</b> , to <b>3-10</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3-10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Maurice B Furlong Jr</b>  |  | DEGREE<br><b>—</b>   |  | 22c. DATE SIGNED<br><b>3-11/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAURICE B FURLONG JR</b>   |  | 22e. ADDRESS<br><b>7620 York Road Towson MD 21204</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3-13-1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BAITO MARYLAND</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPLOF</b>   |  | ADDRESS<br><b>8800 HARBOR ROAD</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please improve carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene for national registration and removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, no medical investigation will be notified during.

BP



UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

Evans



072059

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 4 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sister Helen Agnes McGee</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 5, 1986</b>                          |   | 2b. HOUR<br><b>2:59p<sub>M</sub></b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 31, 1921</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>11</b>  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Philadelphia, Pa</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Stevenson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa Julie Infirmary</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Education</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b>  |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Stevenson</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick L. McGee</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nell Carlin</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>209-40-2363</b>  |  | 17. INFORMANT<br><b>Sr. Catherine Dolores Cress</b> ADDRESS<br><b>21153 1531 GreenSpring Valley Rd.</b> |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>intermittent disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>coronary artery disease</b>   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>1 yr</b><br><b>2 yrs</b>                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>g</b>   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2 Feb</b> 19 <b>84</b> to <b>5 Mar</b> 19 <b>86</b> .<br>saw the deceased alive on <b>2 Mar</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 22b. SIGNATURE<br><b>S. Demarcos</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>7 Mar 86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. DEMARCOS MD</b>  |   | 22e. ADDRESS<br><b>333 ST. Paul Pl 21202</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>March 8, 1986</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sisters of Notre de Namur</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ilchester, Maryland Howard</b>                         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>   |   | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1986</b>   |  |
|   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John H. ...</b>  |  |

BP

DHMM - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 4 2

REG. NO.

|   |  |   |  |   |  |  |   |   |   |  |
|---|--|---|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph F McGinnis  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03 31 86                        |   |  | 2b. HOUR<br>10 <sup>15</sup> A.M.  |   |   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 23 13  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>8. UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTO. MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>County MD.   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO. CO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Stella Maris |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING YEAR)<br>STREET SWEEPER   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>BALTO. CITY  |   |  |
| 13a. STATE<br>MD.   |  |   | 13b. COUNTY<br>BALTO. CO.  |   | 13c. CITY OR TOWN<br>TOWSON  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>240 ROGERS FORGE RD 21212 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN J. MCGINNIS  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNIE T. FINNERTY     |   |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   | 16b. SOCIAL SECURITY NO.<br>217-165429                                 |   | 17. INFORMANT<br>FAMILY RECORDS  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Heart failure<br>DUE TO, OR AS A CONSEQUENCE OF (b). Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (c).<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH             |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/22 19 83, to 3/31 19 86, that (I) (we) last saw the deceased on 3/31 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br>H. Faulkner MD  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>3/31/86                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FAULKNER   |  |   | 22e. ADDRESS<br>2309 Delaney Valley Rd<br>Baltimore, MD 21204          |   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>4-2-1986  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. JOSEPH CHURCH CEM.                   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>TOWSON BALTO. CO. MD.   |   |  |
| 24. FUNERAL DIRECTOR<br>EVANS CHAPEL OF CHIMES  |  |   | 24b. ADDRESS<br>2325 YORK RD<br>TIM, MD. 21093                         |   | 25a. DATE RECEIVED BY REGISTRAR<br>APR 04 1986                                 |  |   | 25b. REGISTRAR'S SIGNATURE<br>J. M. Davidson  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as being 1B shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 4 3

REG. NO

|  |  |   |   |  |   |   |   |  |  |   |   |   |  |
|--|--|---|---|--|---|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BESSIE MC GLOVE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>24</b> YEAR <b>86</b>            |  |   | 2b. HOUR<br><b>10 50 P M</b>  |   |  |  |   |   |   |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>CAU</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>10</b> YEAR <b>95</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b> |   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. MD.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>County</b> MD.                                  |   |  |  |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>PARKVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Perring Pkwy Nsg Home</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BOOKKEEPER</b>      |   |  | 12b KIND OF BUSINESS OR INDUSTRY   |   |   |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD.</b>  |  |   |   | 13b COUNTY<br><b>BALTO.</b>  |   | 13c CITY OR TOWN  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   | 13e STREET ADDRESS / ZIP CODE<br><b>1707 EDGEWOOD RD. 21234</b> |  |
| 14 FATHER'S NAME<br>FIRST <b>WILLIAM</b> MIDDLE <b>T.</b> LAST <b>McGLOVE</b>  |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>ANNIE</b> MIDDLE <b>L.</b> LAST <b>COLLINS</b>   |   |   |   |  |  |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |   | 16b SOCIAL SECURITY NO.<br><b>216-07-7391</b>  |   | 17 INFORMANT ADDRESS<br><b>FAMILY RECORDS</b>   |   |  |  |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASHELD - CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Dementia due to multiple infarcts.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |  |   |   |  |   |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |  |   |   |  |   |   |   |  |  |   |   |   |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3 15 P.M. 7 19 86</b> |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)<br><b></b> |   |  |  |   |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |   | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY, OFFICE FARM, ETC.)          |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |   |   |  |
| 22. I certify that (I) (the hospital) attended the deceased from <b>July 1, 19 70</b> , to <b>Mar 24, 19 86</b> , that (I) (we) last saw the deceased alive on <b>3/25</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |   |   |  |  |   |   |   |  |
| 23a SIGNATURE<br><b>Donald W. Minzer M.D.</b>  |  |   |   |  |   | DEGREE  |   |  | 23b. DATE SIGNED<br><b>3/24/86</b>   |   |   |   |  |
| 23c PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald W. Minzer M.D.</b>   |  |   |   |  |   | 23d ADDRESS<br><b>3009 EVERGREEN AVE BALTO MD</b>   |   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>  |   |   |   |  |
| 23f. REGISTRAR'S SIGNATURE<br><b>John Devlin</b>   |  |   |   |  |   | 23g. REGISTRAR'S SIGNATURE<br><b>John Devlin</b>  |   |  |  |   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |   | 23b DATE<br><b>3-27-1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL CEM.</b> |   |   | 23d. LOCATION<br>CITY OR TOWN <b>BALTO. CITY</b> COUNTY <b>MD.</b> STATE <b>MD.</b>            |  |   |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>EVANS CHAPEL OF MEMORIES</b> ADDRESS <b></b>  |  |   |   |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>  |   |  |  |   |   |   |  |

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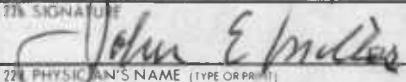

00-00590

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 - 0 7 0 4 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |   |  |  |
|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Marie J. McLemore</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/13/86</b> |   | 2b. HOUR<br><b>4:45p M</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 10, 1923</b>                                   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N Charles St GBMC</b>               |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 13a. STREET ADDRESS / ZIP CODE<br><b>107 Kenilworth Park Dr., Apt. 3C 21204</b>  |   |   |  |  |
| 13b. STATE<br><b>Maryland</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Felix Gasser</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Tina Montalo</b>   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>102-14-7007</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Herbert E. McLemore - Same as #13e</b>                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute congestive failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic lymphatic leukoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastasis to right bronchus</b><br><b>Esophageal carcinoma post op 10/85</b> |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>9 years</b><br><b>post radiation 1 week</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Carcinoma of breast</b>   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>10/85</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 85</b> , to <b>3/13 86</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/13 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |
| 22b. SIGNATURE<br>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |   | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. John E Miller</b>  |  | 22e. ADDRESS<br><b>7401 Osler Dr Towson Md 21204</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-17-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                                     |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto., Md.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |   |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br>                                      |   |   |  |  |

DHMH - 16 60M 7/B4  
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



NOTICE

W. J. H. H.

W. J. H. H.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD F. MEISER</b>                          |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 27 '86</b> |   |  | 2b. HOUR<br><b>2:00 A.M.</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 11 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Office Worker</b>        |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Black &amp; Decker</b>                          |  |  |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Herbert F. Meiser</b>                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Burns</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II 212-18-3840</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Stephen Rottmann 1214 Elmridge Ave. Arbutus Md. 21229</b>  |  |   |  |

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) **CHRONIC OBSTRUCTIVE LUNG DISEASE**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.DUE TO, OR AS A CONSEQUENCE OF  
(b) **ASPIRATION PNEUMONIA**DUE TO, OR AS A CONSEQUENCE OF  
(c) **HYPONATREMIA**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/07</b> , 19 <b>86</b> , to <b>3/27</b> , 19 <b>86</b> , that (I) (we) last<br>saw the deceased alive on <b>3/27</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Jonathan J. Tye, M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/27/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JONATHAN J. TYE, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>GBMC-6701 N. CHARLES ST. Towson, MD.</b>  |  |   |  |

MEDICAL CERTIFICATION

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/31/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leroy M. &amp; Russell C. Witzke Funeral Home 1630 Edmondson Ave. Catonsville, Md. 21228</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 02 1986</b>                 |  |   |  |
|   |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>         |  |   |  |

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00-00490

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 7 0 4 6

REG. NO.

|  |  |  |   |  |   |   |   |
|--|--|--|---|--|---|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Edward E. Mekolon  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>March 14 86 |  |   | 2b HOUR<br>~6:30 P M  |   |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>9 5 34  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS                                    |   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                  |   |
| 10 CITY OR TOWN OF DEATH<br>Dundalk  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7223 Martell Ave 21222 |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tin Mill |   |
|  |  |  |   |  |   | 12b KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel                             |   |
| 13a STATE<br>Maryland  |  |  |   | 13b COUNTY<br>Baltimore  |   | 13c CITY OR TOWN<br>Dundalk   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Adolph Mekolon  |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emma Nemczyk   |   |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-30-0735  |   | 17 INFORMANT<br>ADDRESS<br>Mary C. Mekolon Same as 13e   |   |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Prostatic Cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |   |  |   |   |   |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3/14</u> 19 <u>86</u> to <u>mar</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/14</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |   |   |
| 22b SIGNATURE<br><u>Dr. Ralph D. Baer</u>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   | 22c DATE SIGNED<br>3/16/86  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Ralph D. Baer  |  |  |   | 22e ADDRESS<br>1390 Martin Blvd.   |   |   |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>3/17/86  |   | 23c NAME OF CEMETERY OR CREMATORY<br>Christ Lutheran   |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dundalk Baltimore MD.          |   |
| 24 FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>7922 Wise Ave. Baltimore, MD. 21222   |  |  |   | 25a DATE REC'D. BY REGISTRAR<br>MAR 17 1986  |   | 25b REGISTRAR'S SIGNATURE<br><u>G. E. Anderson-Randall</u>                  |   |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please detach page 2 and send it to the funeral director. Page 1 only should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07047

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-RM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

|   |  |                         |                                       |  |  |   |   |  |  |  |
|---|--|-------------------------|---------------------------------------|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ANTHONY J. MEMMO</b>  |  |                         |                                       |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br><b>3-4-86</b> 19   |   | 2b. HOUR<br>M<br><b>3:15a</b>  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |                                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 31 1943</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>42 YRS.</b>  |   | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>IF UNDER 24 HRS.</b>               |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         |                                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                    |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  |                         |                                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Transportation</b> |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B.G. &amp; E.</b>   |  |                         |                                       |  |  |   |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         | 13b. CITY OR TOWN<br><b>Baltimore</b> |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7840 Lockwood Road</b> 21222 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gessippi Memo</b>  |  |                         |                                       |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Vecchione</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |                                       | 16b. SOCIAL SECURITY NO.<br><b>212-42-1370</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Dorothy C. Memmo</b> Same as 13e   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |                         |                                       |  |  |   |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |                         |                                       |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |                                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |                                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |                                       |  |  |   |   |  |  |  |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u>   |  |                         |                                       |  |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |   | DATE SIGNED <b>3-4-86</b>  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  |                         |                                       |  |  | ADDRESS <b>111 Penn Street</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         | 23b. DATE<br><b>3/8/1986</b>          |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b><br>ADDRESS<br><b>7922 Wise Avenue Dundalk, Maryland 21222</b>  |  |                         |                                       |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>APR 8 1986</b>   |   |  |  |  |

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MADE IN U.S.A.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Leon</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>March 18, 1986</b>   |  |
| 3. SEX <b>Male</b>   |  | 2b. HOUR <b>4:30p<sub>M</sub></b>  |  |
| 4. RACE <b>Caucasian</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>3 - 14 - 1922</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>64</b> YRS  |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Med. Cen.</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>Sunpapers</b>   |  | 13a. CITY OR TOWN OF DEATH <b>Balto.</b>   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Balto.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Merchansky</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stella Jopski</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  | 16b. SOCIAL SECURITY NO. <b>209-14-9756</b>  |  |
| 17. INFORMANT ADDRESS <b>San Diego, Cal.</b>   |  | 18. INFORMANT <b>Bernice Groff, 2737 Cadiz Street</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypovolemic shock</b>  |  | <b>4 h.</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>GI bleeding</b>  |  | <b>4 h.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Small cell carcinoma of lung, Congestive heart failure.</b>  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) this hospital attended the deceased from <b>January 1986</b> to <b>March 1986</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) |  |  |  |
| 22a. SIGNATURE <b>Patricia Disharoon MD</b> DEGREE <b>MD</b>   |  | 22b. DATE SIGNED <b>3/20/86</b>  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patricia Disharoon, M.D.</b>  |  | 22d. ADDRESS <b>3400 Brehms Lane, Baltimore, MD 21213</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>   |  | 23b. DATE <b>3/24/86</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR <b>Joseph N. Zannino, 263 S. Conkling St.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAR 24 1986</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Russell</b>  |  | 25c. REGISTRAR'S SIGNATURE   |  |

March 10, 1964

Chas. E. Smith

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John in New York City, New York

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 4 9

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE - LAST MEYERS  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03-11-1986  |  | 2b. HOUR<br>12:58AM  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-20-1891  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94 YRS  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Germany   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. County Gen. Hosp. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bareback Rider   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Circus  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS / ZIP CODE<br>6811 Campfield Rd. 21207                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>August Gebhardt   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Wilhemenia Eitel   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-03-1353  | 17. INFORMANT ADDRESS<br>11402 Notchcliff<br>Mr. Rudolph Gebhardt Glen Arm, Md.  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>03/10</u> , 19 <u>86</u> , to <u>03/11</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>03/11</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Allen J. Chircus M.D.</u>  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>03/11/86   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Allen J. Chircus M.D.  |   |   | 22e. ADDRESS<br>Balto. County General Hospital   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal   | 23b. DATE<br>3/11/86  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 14 1986   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-00024

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |  |   |   |   |   |  |   |  |
|--|-------------------------|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAUL F. MICELI</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 3-2-86 |   |   | 2b. HOUR<br>M   |  |   |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-24-27</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>58</b> YRS.                            | 7. IF UNDER 1 YR.<br>MONTHS DAYS  | 8. IF UNDER 24 HRS.<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>3-10-86   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county</b> MD  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1411 Hadwick Drive Apt. I</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LITHOGRAPHER</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CAN MANUFACTUR</b>                       |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |                         |  | 13b. CITY OR TOWN<br><b>ESSEX</b>   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET ADDRESS<br><b>1411 HADWICK DRIVE APT. I</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SANTO</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FORTUNATO D'ANNA</b>        |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |   |  |
| 16a. SOCIAL SECURITY NO.<br><b>217-20-7849</b>   |                         |  | 17. INFORMANT<br>ADDRESS<br><b>ROSE MARY CURTIS 2117 DUNDALK AVENUE</b>         |   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |                         |  |   |   |   |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                               |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                     |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Margareta A. Korell</i>   |                         |  | TITLE (SPECIFY)<br>M.D. Assistant   |   |   | DATE SIGNED<br>3-11-86  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                         |  | ADDRESS<br><b>111 Penn Street</b>   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         |  | 23b. DATE<br><b>3-13-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>                                   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTIMORE MARYLAND</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BRADLEY FUNERAL HOME</b>  |                         |  | ADDRESS<br><b>2135 DUNDALK AVENUE</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 12 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1 (SEE PAGE 3 FOR YOUR FILES). TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))



NOV 19 1964

00-00283

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR\_A15 ME (5))  
20M 4 '82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                             |  |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |
|--|--|-----------------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |                             |  |  |  |   |  |   |  | REG. NO. 6 6 0 7 0 5 1   |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LENA A. MILCAREK</b>  |  |                             |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>March 18 1986</b>                                    |  |   |  |  |  |  |  |  |  |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>W</b>          |  | 5 DATE OF BIRTH<br>(MONTH DAY YR) <b>9 - 3 - 22</b>  |  | 6 AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>63</b> |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS.   |  | 7c. DATE PRONOUNCED DEAD<br><b>March 8 1986</b>                                     |  | 7d. DATE OF DEATH<br><b>March 8 1986</b>                                       |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>HEARTWELL, GA.</b>   |  |                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITES STATES</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <b>XX</b> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>                     |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  |                             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE)<br><b>ST JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK)<br><b>RETIRED</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                             |  |  |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b> |  | 13c. CITY OR TOWN<br><b>BALTO</b>  |  | 13e. STREET ADDRESS<br><b>2501 LINWOOD RD</b> |  | 13f. CITY OR TOWN<br><b>21234</b>   |  | 13g. STREET ADDRESS<br><b>2501 LINWOOD RD</b>  |  | 13h. CITY OR TOWN<br><b>21234</b>   |  | 13i. STREET ADDRESS<br><b>2501 LINWOOD RD</b>                                  |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>LEONARD GARLAND SANDERS</b>  |  |                             |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br><b>ESSIE FLEMMING</b>  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |                             |  | 16b. SOCIAL SECURITY NO.<br><b>214-20-1121</b>   |  |   |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                             |  |  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>2+ yrs</b> |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                             |  |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |  |  |  |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                             |  |  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Charles F. Downe</b>  |  |                             |  | TITLE (SPECIFY)<br><b>MD</b>   |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br><b>3/8/86</b>  |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |                             |  | ADDRESS  |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |                             |  | 23b. DATE<br><b>MAR. 11, 86</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE, BALTO. CO. MD.</b>      |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPEL OF MEMORIES, PARKVILLE</b>   |  |                             |  | ADDRESS  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR. 14 1986</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |  |  |  |  |  |  |

0-00500

WALLINGFORD COUNTY

WALLINGFORD COUNTY

WALLINGFORD COUNTY

WALLINGFORD COUNTY

WALLINGFORD COUNTY

0-00500

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 Q 7 0 5 2

REG. NO.

|  |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN H MILCHLING</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 - 15 86</b>               |   | 2b. HOUR<br><b>4:20 PM</b>                                     |   |  |  |  |  |  |  |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 26 10</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 24 HRS<br>HOURS MIN                     |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>COUNTY - BALTO</b> MD.                               |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. - Printer</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Rudco Printing</b>   |  |  |  |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br><b>6512 BELLE VISTA AVENUE 21206</b>   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Fredrick Milchling</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Julianne Burke</b>  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-3234</b> |  | 17. INFORMANT<br>ADDRESS<br><b>John F. Milchling 6512 Belle Vista Ave. 21206</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ischemic Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ischemic Cardiomyopathy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial infarction</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b> P.M.      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>GOACITY K. PATTERSON</b>  |  |   |  |   |  | DEGREE  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GOACITY K. PATTERSON</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>2926 B. Cold Spring Lane Balto., Md.</b>                                     |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3-19-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lossahn Funeral Home</b>  |  |   |  |   |  | 4401 BELAIR RD.<br>ADDRESS<br><b>BALTO. MD 21236</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |  |  |  |  |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 260 and 261 and 262 and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 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and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

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BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED OCT 10 1963

UNITED STATES

DEPARTMENT OF JUSTICE





00-01158

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial-transit permit. Then please remove completed page 3 from this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 5 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |  |  | 2a DATE OF DEATH MONTH DAY YEAR   |  |  | 2b HOUR   |  |  |
| Leroy   |  |  | Miller   |  |  | 3-20-86   |  |  | 8:20 PM   |  |  |
| 3 SEX   |  |  | 4 RACE   |  |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  |  |
| male  |  |  | Black  |  |  | 1 7 1910  |  |  | 76 YRS  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b CITIZEN OF WHAT COUNTRY?  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| Virginia  |  |  | U.S.   |  |  |   |  |  | BALTO Co MD.  |  |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |
| Baltimore   |  |  | Kenesaw Nursing Home   |  |  | construction worker   |  |  |   |  |  |
| 13a STATE   |  |  | 13b COUNTY   |  |  | 13c CITY OR TOWN  |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| Maryland  |  |  |  |  |  | Baltimore   |  |  | 5100 Dickey Hill Road   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b SOCIAL SECURITY NO.   |  |  |
| Joseph a Miller   |  |  | Virginia Clark   |  |  |   |  |  |   |  |  |
| 17 INFORMANT ADDRESS  |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple CVA</u> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Chronic organic brain syndrome</u>   |  |  | 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>2/9/81</u> 19 <u>81</u> to <u>3/20</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>2/28</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  | 22b SIGNATURE <u>Chetner</u> DEGREE <u>MD</u>  |  |  | 22c DATE SIGNED <u>3/21/81</u>  |  |  |   |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e ADDRESS  |  |  | 22f ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                     |  |  |   |  |  |
| Gebremariam, Moses  |  |  | 4115 Wilkens Ave Balto 21229   |  |  |   |  |  |   |  |  |
| 23a BURIAL CREMATION, REMOVAL (SPECIFY)   |  |  | 23b DATE <u>3/26/86</u>  |  |  | 23c NAME OF CEMETERY OR CREMATORY <u>Garrison-Farrest VA C.</u>   |  |  | 23d LOCATION CITY OR TOWN COUNTY STATE <u>Garr. Co. Md.</u>                                 |  |  |
| 24 FUNERAL DIRECTOR NAME <u>Carroll</u> ADDRESS <u>1712 W. North Ave</u>  |  |  | 25a DATE REC'D. BY REGISTRAR <u>MAR 24 1986</u>  |  |  | 25b REGISTRAR'S SIGNATURE <u>J. W. Davidson-Randall</u>   |  |  |   |  |  |

MEDICAL CERTIFICATION

*[Faint, illegible text throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~return this page~~ return it to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other ~~circumstances~~ circumstances, the medical examiner must be notified at once.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other trauma, then the medical examiner must be notified at once.

**MEDICAL CERTIFICATION**

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8607054   |  |   |  |
|--|--|---|--|---|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mabel C. MINITOR  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 9, 1986  |  | 2b. HOUR<br>1:30 a.m.   |  |
| 3. SEX<br>FeMale   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 26 1917   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR ACT OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>Balto.   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Mitten Hitt  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Shiflett   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>219-12-6546   |  | 17. INFORMANT ADDRESS<br>Nancy Smith 821 Wiseburg Rd. White Hall Md. 21161  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic Obstructive Pulmonary Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                             |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:6  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 2-11 19 86 to 3-9 19 86, that (X) (we) last saw the deceased alive on 3-9 19 86, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Martin B. Getzow   |  |   |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/9/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Martin B. Getzow  |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr. 21237  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/12/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rossville Balto. Maryland   |  |
| 24. FUNERAL DIRECTOR<br>Connelly Funeral Home 300 Mace Ave. 21221  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 14 1986  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07055

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JESSE S. MINNIEAR</b>   |   |   | 2a. DATE OF DEATH <b>March 30 1986</b>  |  | 2b. HOUR <b>12:50 A.M.</b>   |
| 3. SEX <b>Male</b>   | 4. RACE <b>White</b>  | 5. DATE OF BIRTH <b>Sept. 22, 1899</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>INDIANA</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co. MD.</b>                                       |  |  |
| 10. CITY OR TOWN OF DEATH <b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Old Court Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffer (ret)</b>              | 12b. KIND OF BUSINESS OR INDUSTRY <b>Taxi</b>                                  |  |
| 13a. STATE <b>MD</b>   | 13b. COUNTY <b>xxxxxxx</b>  | 13c. CITY OR TOWN <b>Baltimore</b>  | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE <b>2522 Tolley St. 21230</b>                    |  |
| 14. FATHER'S NAME<br>FIRST (UNKNOWN) LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST (UNKNOWN) MIDDLE LAST   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>WW I</b>   | 17. INFORMANT ADDRESS<br><b>Dennis Mitchell, Per. Rep. Baltimore, MD</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC OBSTRUCTIVE PULM. DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>ATRIAL FIBRILLATION &amp; ASCVD</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 21g. I certify that (I) (this hospital) attended the deceased from <b>Nov. 19 85</b> to <b>MAR 30 19 86</b> , that (I) (we) lost the deceased alive on <b>MAR 30 19 86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.  |   |   |   |  |  |
| 22a. SIGNATURE<br><b>Ramon S. Minniear</b>   |   |   |   | 22b. DATE SIGNED<br><b>3/31/86</b>   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   |   | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |   | 23b. DATE <b>April 2, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Nichols Bethel Cemetery</b>              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Odenton, AA, MD</b>  |   | 24. FUNERAL DIRECTOR<br>NAME <b>Singleton Funeral Home, Glen Burnie, MD</b> ADDRESS   |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR <b>APR 01 1986</b>   |   |   |   | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>                       |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use on the burial-transit permit. They please remove carbon copies, pages 1 and 2, and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, secondary injury, or other traumatic event, then item 19 should be marked as item 18.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SR ROSE JULIE MINOGUE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-7-86</b>                   |   |  | 2b. HOUR<br><b>11A</b> M  |  |  |  |
| 3. SEX<br><b>F Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 6, 1894</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ireland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Stevenson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa Julie Infirmary</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Receptionist Education</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Stevenson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>21153 1531 Green Spring Valley Rd.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Minogue</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Murry</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>220-54-3101</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Sister Kathleen O'Brien, Same as #13e</b>                          |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Probable massive myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>years</b><br>Approximate interval between onset and death<br><b>3 days</b> |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>3/6</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/6</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>W. S. Goodman M.D.</b>  |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>3/7/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. S. Goodman M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>301 St. Paul Pl. Bkto. 21202</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3-10-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sisters of Notre Dame</b>             |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ilchester, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  |   |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 11 1986</b>                    |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



075013

THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE SECRETARY

MEMORANDUM FOR THE SECRETARY

DATE: 10/10/50

TO: THE SECRETARY

FROM: [illegible]

SUBJECT: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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DO NOT WRITE IN THESE SPACES



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-01194

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |  |  |         |  |
|---|--|--|--|--|--|---|--|--|--|---------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 8607057 |  |
| 1- FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |         |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ALVIN H. MOGOL   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 19 86  |  |   |  | 2b. HOUR<br>8:30 P.M.  |  |         |  |
| 3 SEX<br>MALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>SEPT. 2, 1921   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |  |         |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTIMORE COUNTY GEN. HOSPITAL |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES REPRESENTATIVE           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HATS  |  |         |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE (21215)<br>6503 PARK HEIGHTS AVE. APT. LJ   |  |         |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MAURICE MOGOL  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>REBA LEIBOWITZ   |  |   |  |  |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES WWII ARMY  |  |  |  | 16b. SOCIAL SECURITY NO.<br>131-10-8177  |  | 17. INFORMANT ADDRESS (21215)<br>Mrs. Rita Sapperstein 6711 Park Heights Ave                    |  |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis:</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Small bowel obstruction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |   |  |  |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |   |  |  |  |         |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |         |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-19</u> 19 <u>86</u> to <u>3-19</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3-19</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |         |  |
| 22b. SIGNATURE<br><u>Rayadurg Govinda Rao</u>   |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |   |  | 22c. DATE SIGNED<br><u>3-19-86</u>   |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAYADURG GOVINDA RAO   |  | 22e. ADDRESS<br>BALTIMORE COUNTY GEN. HOSPITAL.  |  |  |  |   |  |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/21/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>AITZ CHAIM CEM.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO., BALTO., MD.                                  |  |  |  |         |  |
| 24. FUNERAL DIRECTOR NAME<br>SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTO., MD. (21215)  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 24 1986  |  | 25b. REGISTRAR'S SIGNATURE   |  |         |  |



070013

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 6 0 7 0 5 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |   |  |   |  |
|---|--|--|---|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Richard MOHR</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 4, 1986</b>  |  |  | 2b HOUR<br><b>8:25P M</b>   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 19 1944</b>   |  | 6 AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>41</b>                                      |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS</b>   |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Md.</b> 13b COUNTY <b>Balto.</b> 13c CITY OR TOWN <b>Essex</b>   |  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>338 Oberle Ave. 21221</b>                  |   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Fred H. Mohr</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora V. Wilkerson</b>  |  |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b SOCIAL SECURITY NO.<br><b>218-42-2088</b>  |   | 17 INFORMANT<br>ADDRESS<br><b>Norman Mohr 338 Oberle Ave. 21221</b>  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |   |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 3, 1980</b> to <b>present</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>February 4, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.)                         |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>E. WeisBrot</b>  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>3/5/86</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Eric WeisBrot</b>   |  |  | 22e. ADDRESS<br><b>406 Eastern Blvd.<br/>Balto., Md. 21221</b>  |  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>3/8/1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Lutheran Cemetery</b>            |   | 23d. LOCATION<br>(CITY OR TOWN)<br><b>Essex Baltimore Maryland</b> |   |  |
| 24 FUNERAL DIRECTOR<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1986</b>                             |   | 25b. REGISTRAR'S SIGNATURE   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hospital after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



00-01869

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 5 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |   |  |  |   |  |
|--|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Virginia M. Monacelli</b>  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 26, 1986</b>                                    |   | 2b HOUR<br><b>10:50a</b>   |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>CAUCASIAN</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 01 1988</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10 CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>   | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            | 12b KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>                                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  |  |   |  |
| 13a STATE<br><b>MARYLAND</b>   | 13b COUNTY<br><b>BALTIMORE</b>  | 13c CITY OR TOWN<br><b>ROSEDALE</b>  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE<br><b>6300 KENWOOD AVE. 21237</b>                     |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RALPH ----- GAMBINI</b>  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>-----</b>   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b SOCIAL SECURITY NO.<br><b>170100251</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>ORNELLA FRANCUS 1213 GETTIG RD.</b>                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia - bilateral</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Congestive Heart Failure</b>  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |   |  |
| 19a DATE OF OPERATION  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a I certify that (this hospital) attended the deceased from <b>March 24</b> 19 <b>86</b> to <b>March 26</b> 19 <b>86</b> , that (we) last saw the deceased alive on <b>March 26</b> 19 <b>86</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |   |  |  |   |  |
| 22b SIGNATURE<br><b>Dr. Mahoney</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c DATE SIGNED<br><b>3-26-86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Mahoney</b>   |   | 22e ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b DATE<br><b>03/29/86</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>                                   |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD.</b>  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>John 1211 Chesaw Ave.</b>  |   | ADDRESS  |  | 25a DATE RECD. BY REGISTRAR<br><b>MAR 27 1986</b>                                   | 25b REGISTRAR'S SIGNATURE<br><b>John Davidson-Russell</b>  |

MEDICAL CERTIFICATION

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DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-01441

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 7 0 6 0  
REG. NO.

|   |  |   |  |   |                            |  |
|---|--|---|--|---|----------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>PARSEY (PORSEY) J. MOORE, Jr.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 22, 1986</b> |   | 2b. HOUR<br><b>11 p.m.</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 10 8 1919</b>  |                            |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>66</b>  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                       |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                            |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. County General Hospital</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Galvanizer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |                            |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>5509 Old Court Rd., Md 21207</b>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Parsey Moore, Sr.</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eliza Moore</b>                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>246-18-1642</b>  |  | 17. INFORMANT<br><b>Leathia Moore</b>   |  | ADDRESS<br><b>5509 Old Court Rd. 21207</b>  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of the lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>chronic obstructive lung disease</b>  |  |   |  |   |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 20, 1986</b> to <b>March 22, 1986</b> that (I) (we) lost<br>saw the deceased alive on <b>March 22, 1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not view the body after death.                                       |  |   |  |   |                            |  |
| 22b. SIGNATURE<br><b>Ghassem Pourmottarbed, M.D.</b>  |  |   |  | 22c. DATE SIGNED<br><b>3-22-86</b>  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GHASSEM POURMOTTARBED</b>   |  |   |  | 22e. ADDRESS<br><b>Balto. Co. Gen. Hospital</b>   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-29-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moore Cemetery</b>   |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Aurora, North Car.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>                                   |  |   |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marshall W. Jones, Jr</b>  |  | ADDRESS<br><b>4101 Edmondson Ave. 21229</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Marshall W. Jones, Jr</b>  |                            |  |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in envelope, carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 6 1

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |  |   |  |   |   |  |
|---|--|---|--|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bertha Agnes MORRIS  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 15, 1986                  |   |   | 2b. HOUR<br>3:50A M  |   |  |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 26 1906  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Dundalk                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>908 Oakleigh Beach Road 21222 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Christian Kahl  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes M. Price        |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |   |  |   | 16b. SOCIAL SECURITY NO.<br>220-22-5098 |  |
| 17. INFORMANT<br>Herbert Arrington  |  |   | ADDRESS<br>910 Oakleigh Beach Rd<br>Balto., MD. 21222                  |   |   |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest   |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Hemophilus Influenza Pneumonia  |  |   |  |   |   |  |   |  |   |   |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |   |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Severe peripheral vascular disease  |  |   |  |   |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                         |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from February 28, 1986, to March 15, 1986, that (I) (we) last saw the deceased alive on March 15, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |  |   |   |  |
| 22a. SIGNATURE<br>John Merwin, MD   |  |   |  |   |   | DEGREE<br>MD   |   |  | 22c. DATE SIGNED<br>3/15/86                                     |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Merwin, MD  |  |   |  |   |   | 22e. ADDRESS<br>9000 Franklin Square Drive, 21237  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>3/18/1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 17 1986   |   | 25b. REGISTRAR'S SIGNATURE   |   |   |  |

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

BP

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2005 JUL 10



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 6 2

|  |  |  |  |
|--|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Marvin Wesley Moss</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 5, 1986</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 12, 1941</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Missouri</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Reisterstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT AT SUCH FACILITY, GIVE STREET ADDRESS)<br><b>320 Wembley Road</b> |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Computer Tech.</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Md. Balto. Reisterstown</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Marvin Harry Moss</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Ellie Belle Lacey</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>1959-1963 491-46-5385</b>   |  |
| 17. INFORMANT<br><b>Edna Jean Moss</b>   |  | 18. ADDRESS<br><b>320 Wembley Road Reisterstown, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pneumonia - Bacterial</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Days</b> |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>End Stage Renal Disease - CAPD (Home Dialysis)</b>   |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING TO CAUSE OF DEATH<br>(IF EITHER CATEGORY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>  |  |
| 21a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, PUBLIC PLACE, ETC.)<br><b>N/A</b>   |  |
| 22a. I certify that (1) (the hospital) attended the deceased from <b>Feb 28</b> 19 <b>86</b> to <b>March 5</b> 19 <b>86</b> and that in my opinion death occurred on the date and hour and from the causes stated above. (If not, state when and where death occurred.)  |  | 22b. SIGNATURE<br><b>Paul Douglas Light MD</b>   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL DOUGLAS LIGHT</b>   |  | 22d. ADDRESS<br><b>22 S. GREENE ST. BALTIMORE MD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>March 7, 1986</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial Park</b>  |  | 23d. LOCATION<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br><b>H. F. Schmitt</b>   |  | 25. DATE RECD. BY REGISTRAR<br><b>MAR 6 1986</b>   |  |

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked as item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

083013

March 2, 1961

March 12, 1961

Baltimore County

Director

Mr. J. Edgar Hoover

Washington, D.C.

Dear Mr. Hoover:

(Enclosed for Mr. Tolson)

Very truly yours,

John Edgar Hoover

00-02348

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 6 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |                              |   |       |   |      |   |  |
|---|------------------------------|---|-------|---|------|---|--|
| 2a. DATE OF DEATH   |                              |   | MONTH | DAY   | YEAR | 2b. HOUR  |  |
| JOHN Harrison MUDD  |                              |   | 03    | 31  | '86  | 2:00P M.  |  |
| 3. SEX  | 4. RACE                      | 5. DATE OF BIRTH  |       | 6. AGE (IN YEARS LAST BIRTHDAY)   |      | 7. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Male  | White                        | October 26 1923   |       | 62 YRS.   |      | BALTIMORE COUNTY, MD.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |       | 9. BALTIMORE CITY OR COUNTY OF DEATH  |      | 10. CITY OR TOWN OF DEATH   |  |
| Hawaii  | USA                          |   |       | BALTIMORE COUNTY,   |      | TOWSON  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                          |                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |       | 12b. KIND OF BUSINESS OR INDUSTRY   |      | 13. STREET ADDRESS / ZIP CODE   |  |
| GREATER BALTIMORE MEDICAL CENTER  |                              | Attorney  |       | Law   |      | 1307 Milldam Rd., 21204   |  |
| 14. FATHER'S NAME   |                              | 15. MOTHER'S MAIDEN NAME  |       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)                  |      | 16b. SOCIAL SECURITY NO.  |  |
| Kostka  |                              | Irma Iris Harrison  |       | Yes   |      | 579-14-5426   |  |
| 17. INFORMANT   |                              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |       | 19a. DATE OF OPERATION  |      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| Marion F. Mudd, 1307 Milldam Rd., 21204   |                              | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENO CANCER LUNG<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) |       | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      | 20b. IF WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |                              | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |       | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                              |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                          |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |       | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |      | 22a. I certify that (I) (this hospital) attended the deceased from 3/27 1986 to 3/31 1986, that (I) (we) last saw the deceased alive on 3/31 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22b. SIGNATURE  |                              | 22c. DATE SIGNED  |       | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |      | 22e. ADDRESS  |  |
| Alan Malouf   |                              | 3/31/86   |       | ALAN MALOUF, M.D.   |      | GBMC - 6701 N. CHARLES STREET   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |                              | 23b. DATE   |       | 23c. NAME OF CEMETERY OR CREMATORY  |      | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Cremation   |                              | 4/2/86  |       | Westview Crematory  |      | Catonsville Balto. Md.  |  |
| 24. FUNERAL DIRECTOR NAME   |                              | 25a. DATE REC'D. BY REGISTRAR   |       | 25b. REGISTRAR'S SIGNATURE  |      | 25c. DATE REC'D. BY REGISTRAR   |  |
| Martin D. Lawson, 10 W. Padonia Rd. 21093   |                              | APR 02 1986   |       | John D. Dwyer   |      |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP  
DHMH - 16 60M 7/B4  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-02840

BOX COTTON FIBER

100% COTTON FIBER



BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  | REG. NO. 86 07064   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ALLAN W. MUND, JR.  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 19 86                                       |   | 2b. HOUR<br>8:30 AM  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 3, 1935   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>116 Yorkleigh Road |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Education   |
| 13a. STATE<br>MD  |  |   |  | 13b. COUNTY<br>Balto.   | 13c. CITY OR TOWN<br>Towson  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Allan W. Mund, Sr.  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Irma Kaufman   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1957-61  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Allan W. Mund, Jr., Same   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY DYSFUNCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>AMYOTROPHIC LATERAL SCLEROSIS</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>10 months</u><br><u>4 years</u> |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>DEBILITATION, CHRONIC ILLNESS</u>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>AUGUST 19 85</u> to <u>MARCH 19 86</u> , that (I) (last) saw the deceased alive on <u>MARCH 17 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>James F. Johnston MD</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>March 19 86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES F JOHNSTON MD  |  |   |  | 22e. ADDRESS<br>GSPDB 5601 62th RAVEN BLVD 21239  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/22/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAR 20 1986 <u>John Davidson-Randall</u>  |  |   |  |

Entail 8/22/66 1000 Park  
Henry W. Jenkins & Son Co.  
New York, N.Y. 10017

Yes 1000 Park 1000 Park  
W. 1000 Park 1000 Park  
Bldg. 1000 Park 1000 Park  
Township 1000 Park 1000 Park  
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Education  
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00-01845

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 7 0 6 5  
REG. NO.1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |                      |  |  |   |  |                                |  |
|---|--|---|--|--|----------------------|--|--|---|--|--------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MILDRED MIDDLE MARIE LAST Myers   |  |   | 2a DATE OF DEATH<br>MONTH 3 DAY 25 YEAR 86 |  | 2b HOUR<br>3 45 P.M. |  |  |   |  |                                |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>January 23, 1900  |                      | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                    |  | 8 IF UNDER 14 HRS<br>HOURS MIN |  |
| 9a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |  |                                |  |
| 10 CITY OR TOWN OF DEATH<br>Catonsville   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Summit Nursing Home |  |  |                      | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Own Home                  |  |                                |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE Maryland 13b COUNTY Baltimore 13c CITY OR TOWN Baltimore |  |   |  |  |                      | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br>740 Charing Cross Road 21229 |  |                                |  |
| 14 FATHER'S NAME<br>FIRST Michael MIDDLE Peters LAST Peters   |  |   |  |  |                      | 15 MOTHER'S MAIDEN NAME<br>FIRST Mary MIDDLE E. LAST Wetzelberger                              |  |   |  |                                |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>212-74-8041  |  | 17 INFORMANT<br>Charles E. Myers   |                      |  |  | ADDRESS<br>624 Braeside Road<br>Baltimore, MD. 21229          |  |                                |  |

|   |  |   |  |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CNS degenerative disease - severe dysphagia

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE HANDS USED<br>IN CAUSING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4 Oct</u> 19 <u>75</u> to <u>23 Mar</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>24 Mar</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b SIGNATURE<br><u>James E. Rowe M.D.</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><u>3/26/86</u>  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>J. E. ROWE</u>  |  |   |  | 22e ADDRESS<br><u>Summit Nursing Home</u>  |  |  |  |

|  |  |                     |  |  |  |  |  |
|--|--|---------------------|--|--|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b DATE<br>3/28/86 |  | 23c NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Maryland |  |
| 24 FUNERAL DIRECTOR<br><u>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</u><br>1630 Edmondson Avenue, CATONSVILLE, MD. 21228 |  |                     |  | 25a DATE REC'D. BY REGISTRAR<br><u>MAR 27 1986</u>     |  | 25b REGISTRAR'S SIGNATURE<br><u>John David Riddle</u>          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

00013-00



00-02055

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 6 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |   |  |  |  |  |
|---|--|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Chad Nathan</i>  |  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3-26-86</i>                    |   |  | 7b. HOUR<br><i>5 A.M.</i>   |   |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>JAN. 1, 1900</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>86</i> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>PIKESVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PIKESVILLE NURSING HOME</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3948 DOLFIELD AVE. #21215</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALEXANDER FALK</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-74-9290</b>  |  | 17. INFORMANT<br><b>SIDNEY BLUMRESS</b>   |  | <b>8200 NINA CT. BALTO., MD</b>   |   | <b>21208</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Alzheimer's Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.             |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____  |  |   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 70a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>3-5-86</i> P.M. 19 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-5-86</i> 19 <i>86</i> , to <i>3-26-86</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>3-5-86</i> 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Harold B. B...</i>   |  |   | DEGREE<br><i>MD</i>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>3-26-86</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Harold B. B...</i>  |  |   | 22e. ADDRESS<br><i>7220 Park Heights Ave.</i>                            |   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |   | 23b. DATE<br><b>MAR. 27, 1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>TIFEREETH ISRAEL ANSHE</b>            |   | 23d. LOCATION<br>SPARDOWN ROSEDALE COUNTY BALTO. STATE MD |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1986</b>                            |   |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John E. ...</i> |  |

BP

11 2 32 00 2

00-0164

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 6 0 7 0 6 7  
REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Anna Pearl Neeb</b>  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 21 1986</b>   |  | 2b HOUR<br><b>1752 M</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 30 1902</b>  |  |
| 6 BIRTHPLACE (SEE INSTRUCTIONS)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 9 CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  |
| 13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Baltimore</b>   |  | 13c CITY OR TOWN<br><b>Woodlawn</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Haymire</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kate Emire</b>  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |
| 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-22-5641</b>   |  | 17 INFORMANT<br>NAME ADDRESS<br><b>Mrs. George Neeb 21050</b><br><b>221 Bynum Ridge Road Forest Hill Maryland</b>                                    |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Electromechanical dissociation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Infarction</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diffuse Pneumonia, U.T.-I</b> |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b SIGNATURE<br><b>Hafeez A Syed</b>  |  | DEGREE   |  | 22c DATE SIGNED<br><b>3/21/86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFAEEZ A SYED MD</b>   |  | 22e ADDRESS<br><b>BALTIMORE COUNTY GEN HOSP</b>  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>03-24-86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Maryland</b>  |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Road Randallstown, Maryland 21133</b>          |  |   |  |
| 25a DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Randall</b>  |  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

100-11841



RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

00-01617

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 10 7 0 6 8

REG NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Sally (Sallie) NELSON</b>  |  | 2a DATE OF DEATH MONTH DAY YEAR <b>03 24 86</b>   |  | 2b HOUR <b>10:20 AM</b>  |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Black</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>9 11 89</b>  |  |
| 6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9 CITY OR TOWN OF DEATH <b>Catonsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Englehook nursing home</b> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. County MD</b>   |  |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Catonsville</b> 13c. CITY OR TOWN <b>Baltimore</b>  |  | 12b USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>   |  | 12c KIND OF BUSINESS OR INDUSTRY   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>William Harris</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROBA</b>   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b SOCIAL SECURITY NO. <b>215-32-0555</b>  |  | 17 INFORMANT ADDRESS <b>EMMA Grace Jackson 4 Shipley Ave</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Aspiration Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Feeding Gastrostomy</b><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a))<br><b>Bilateral Auralization: Rhinorrhea with eyes</b> |  |   |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTO PSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>8 20 85</b> to <b>3 24 86</b> , that (I) (we) last saw the deceased alive on <b>3 8 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b SIGNATURE <b>DSS &amp; Co</b>  |  | DEGREE <b>MD</b>  |  | 22c DATE SIGNED <b>3-24-86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DARSHAN S. SALUJA</b>  |  | 22e ADDRESS <b>1600 MT Royal Ave, Balli 2121</b>  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b DATE <b>3/28/86</b>   |  | 23c NAME OF CEMETERY OR CREMATORY <b>Western Star Cem.</b>   |  |
| 24 FUNERAL DIRECTOR NAME <b>Wm C March F/H West</b>  |  | ADDRESS <b>4300 Wabash Avenue</b>   |  | 25a DATE REC'D BY REGISTRAR <b>MAR 27 1986</b>   |  |
| 25b REGISTRAR'S SIGNATURE <b>J. H. Harrison</b>  |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11







07/84  
25M

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))

| <div style="display: flex; justify-content: space-between;"> <span>FOR<br/>1- STATE<br/>REGISTRAR</span> <span>STATE OF MARYLAND<br/>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br/>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</span> <span style="font-size: 1.2em;">1986-36810</span> </div>   |                         |  |   |   |  |   |  |  |  |
|--|-------------------------|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Clarence James Neslein (Unknown 86-22)</b>  |                         |  |   |   |  | 7a. DATE KNOWN OF DEATH<br>ESTI. MATED <input checked="" type="checkbox"/> 1984     |  | 2b. HOUR<br>M <b>11AM</b>  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>24</b> YEAR <b>63</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>22</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 2c. DATE PRONOUNCED DEAD<br><b>March 6, 19 86</b>                                   |  | 2d. HOUR<br>M <b>11AM</b>  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |                         | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Thristle Road</b>                               |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>unknown</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>unknown</b>  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         | 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>411 Millington Avenue</b>  |                         | 14. FATHER'S NAME<br>FIRST <b>Neslein</b> MIDDLE <b></b> LAST <b></b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b></b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |                         | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  | ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Undetermined</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>   |                         |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |                         |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>UNK</b>  |                         | 21b. TIME OF INJURY<br>HOUR A.M. <b>UNK</b> MONTH <b>UNK</b> DAY <b>19</b> P.M. <b>UNK</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>UNK</b>   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/><br><b>UNK</b>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>UNK</b>  |   | 21f. LOCATION<br>STREET <b>UNKNOWN</b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>  |  |   |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural Causes</b> <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . |                         |  |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>  |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |   |   |  | DATE re-issued<br>SIGNED <b>9/5/02</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |                         | ADDRESS <b>111 Penn St. Baltimore, MD</b>  |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>OCME</b>   |                         | 23b. DATE<br><b>UNK</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SMITHSONIAN</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>WASHINGTON DC</b> COUNTY <b></b> STATE <b></b>     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>OCME</b> ADDRESS <b></b>   |                         | 25. DATE REC'D. BY REGISTRAR <b>OCT 04 2002</b> 25b. REGISTRAR'S SIGNATURE  |   |   |  |   |  |  |  |



0-02614

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8607069

REG. NO.

|  |  |   |  |   |  |   |   |   |   |
|--|--|---|--|---|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOROTHY D. NESS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 31 '86</b>                 |   |  | 2b. HOUR<br><b>11:50P<sup>M</sup></b>   |   |   |   |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 01 1901</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUPPLY FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N.CHARLES ST.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Opticians</b>   |   |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>218 Gaywood Road 21212</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George T. Ness, Sr.</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Belle Dean</b>             |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-03-7301 A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Elizabeth N. Grubb 218 Gaywood Road -12</b>   |  |   |   |   |   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>PULMONARY EDEMA</b><br>(c) <b>CONGESTIVE HEART FAILURE</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HYPERTENSION</b> |  |   |  |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3/25 1986</b>    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/25 1986</b> to <b>3/31 1986</b> , that (I) (we) last saw the deceased alive on <b>3/31 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Joy L. Howard</b> MD  |  |   |  |   |  | DEGREE  |   | 22c. DATE SIGNED<br><b>4/1/86</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOY HOWARD, M.D.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>GBMC-6701 N.CHARLES ST.</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>4/3/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b> |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 4 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified and advised.)

BP

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00-00374

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 6

0 7 0 7 0

REG. NO.

|  |  |   |   |  |   |  |   |   |  |
|--|--|---|---|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Michael Newton</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-9-86</b> |  | 2b HOUR<br><b>3:04A M</b>   |  |   |   |  |
| 3 SEX<br><b>male</b>   |  | 4 RACE<br><b>Black</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-11-47</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>38</b> YRS.                                       |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN. |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Towson MD</b>                                |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Joseph Hospital</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Train, iteak</b> |   | 12b KIND OF BUSINESS OR INDUSTRY                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>md.</b> 13b COUNTY <b>Balto</b> 13c CITY OR TOWN <b>Balto</b>  |  |   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 13e STREET ADDRESS / ZIP CODE<br><b>1808 McCullough St. 712178</b>                     |   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Harry Newton</b>   |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Emory</b>  |   |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-5532</b>   |   | 17 INFORMANT<br>ADDRESS <b>7953 Lorraine Caldwell Wilkes Ln.</b>   |   |  |   |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE Cause (a) <b>Cardiac Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acquired Immune Deficiency Syndrome</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Renal failure</b>   |  |   |   |  |   |  |   |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. certify that (I) (this hospital) attended the deceased from <b>2/4/86</b> to <b>3/9/86</b> that (I) (we) last saw the deceased alive on <b>3/9/86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |  |   |   |  |
| 22b SIGNATURE<br><b>Hassan Makhzoomi</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |   |  |   | 22c DATE SIGNED<br><b>3/11/86</b>                               |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HASSAN MAKHZOUMI</b>  |  |   |   | 22e ADDRESS<br><b>120 Sister Pierre Drive</b>  |   |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>3-14-86</b>  |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto MD</b>                           |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>BROWN-THOMPSON</b>   |  |   |   | ADDRESS<br><b>1913 W 1st St Balto</b>  |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAR 14 1986</b>                                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages require countersignatures. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

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071166

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 7 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                            |  |  |  |  |  |  |
|--|--|--|--|---|----------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Isabelle Noellert</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-8-86</b> |   | 2b. HOUR<br><b>2:00 AM</b> |  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 19 1901</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE<br>STATE OR FOREIGN COUNTRY<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Tawes N.H.</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Balto.</b>  |  |  |  |   |                            | 13b. CITY OR TOWN<br><b>Balto.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS / ZIP CODE<br><b>302 Albemarle St. 21202</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Vincent Montemurro</b>  |  |  |  |   |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Teresa</b>                       |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-9280</b>   |  | 17. INFORMANT<br><b>Irvin Noellert</b>  |                            |  |  | ADDRESS<br><b>Balto., Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio pulmonary arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CVA &amp; Hemiparesis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                            |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |                            |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                            |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-21</b> , 19 <b>78</b> , to <b>3-8</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3-8-86</b> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |  |  |   |                            |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>H. Devadoss</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                            |  |  | 22c. DATE SIGNED<br><b>3/8/86</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. DEVA DOSS</b>   |  |  |  | 22e. ADDRESS<br><b>133 Nursing Home, SG HC.</b>   |                            |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-11-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  |                            |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>  |  |  |  | ADDRESS<br><b>4905 York Rd.</b>   |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 10 1986</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julian Davidson</b>   |  |  |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

021170

11 DE V 4 D 22

22/8/15



071034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 28, show any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |   |                         |  | 8 6 0 7 0 7 2   |                 |   |                 |                                  |  |
|---|--|--|---|--|--|--|---|-------------------------|--|---|-----------------|---|-----------------|----------------------------------|--|
| 1- FOR STATE REGISTRAR  |  |  |   |  |  |  |   |                         |  | REG. NO.  |                 |   |                 |                                  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST   |  | MIDDLE   |  | LAST  |                         | 2a DATE OF DEATH   |   | MONTH           | DAY   | YEAR            | 2b HOUR                          |  |
| HENRY   |  |  | J.  |  | NOOFT  |  | SR  |                         | 3  |   | 6               | 86  | 9:27P M         |                                  |  |
| 3 SEX   |  |  | 4 RACE  |  | 5 DATE OF BIRTH  |  |   |                         | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |   | IF UNDER 1 YEAR |   | IF UNDER 24 HRS |                                  |  |
| Male  |  |  | White   |  | Oct. 4 1906  |  |   |                         | 79   |   | MONTHS          |   | DAYS            |                                  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |                         | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |   |                 |   |                 |                                  |  |
| Baltimore, Md.  |  |  | USA   |  |  |  |   |                         | BALTIMORE COUNTY MD.   |   |                 |   |                 |                                  |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |                         |  |   |                 | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                 | 12b KIND OF BUSINESS OR INDUSTRY |  |
| TOWSON  |  |  | GMC- 6701 N. CHARLES ST.  |  |  |  |   |                         |  |   |                 | Carpenter   |                 | Construction                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |  |   |                         |  | 13d INSIDE CITY LIMITS?   |                 | 13e STREET ADDRESS & ZIP CODE                                   |                 |                                  |  |
| 13a STATE 13b COUNTY 13c CITY OR TOWN   |  |  |   |  |  |  |   |                         |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | 542 Back River Neck Rd. 21221                                   |                 |                                  |  |
| 14 FATHER'S NAME  |  |  |   |  |  |  |   |                         |  | 15 MOTHER'S MAIDEN NAME   |                 |   |                 |                                  |  |
| FIRST MIDDLE LAST   |  |  |   |  |  |  |   |                         |  | FIRST MIDDLE LAST   |                 |   |                 |                                  |  |
| Vincent Nooft   |  |  |   |  |  |  |   |                         |  | Antonia Zygat   |                 |   |                 |                                  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b SOCIAL SECURITY NO.   |  |  | 17 INFORMANT   |   |                         |  |   |                 |   |                 |                                  |  |
| No  |  |  | 213 07 5518   |  |  | 538 Back River Neck Rd.<br>Henry J. Nooft, Jr. Balto., Md. 21221             |   |                         |  |   |                 |   |                 |                                  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY  |  |  |   |  |  |  |   |                         |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |                 |   |                 |                                  |  |
| IMMEDIATE CAUSE (a) BRAIN DEATH SECONDARY TO HYPOXIA WITH CARDIAC ARREST  |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) SQUAMOUS CELL CA LUNG   |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?  |                         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |                 |   |                 |                                  |  |
|   |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |                 |   |                 |                                  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |                         |  |   |                 |   |                 |                                  |  |
|   |  |  | P.M. 19   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |                         |  |   |                 |   |                 |                                  |  |
|   |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| 22a I certify that (I) (this hospital) attended the deceased from 3-6 19 86, to 3-6 19 86, that (I) (we) lost saw the deceased alive on 3-6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| 22b SIGNATURE   |  |  |   |  |  | DEGREE   |   |                         | 22c DATE SIGNED  |   |                 |   |                 |                                  |  |
| David Safferman   |  |  |   |  |  | MD   |   |                         | 3/7/86   |   |                 |   |                 |                                  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  |  | 22e ADDRESS  |   |                         |  |   |                 |   |                 |                                  |  |
| DAVID SAFFERMAN, M.D.   |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| 23a BURIAL, CREMATION, REMOVAL  |  |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |  |   | 23d LOCATION            |  |   |                 |   |                 |                                  |  |
| Burial  |  |  | 3/10/86   |  | Holly Hill Memorial Gardens  |  |   | TOWN Baltimore Co., Md. |  |   |                 |   |                 |                                  |  |
| 25a DATE RECD. BY REGISTRAR   |  |  |   |  |  | 25b REGISTRAR'S SIGNATURE  |   |                         |  |   |                 |   |                 |                                  |  |
| MAR 10 1986   |  |  |   |  |  | John D. ...  |   |                         |  |   |                 |   |                 |                                  |  |
| 26 FUNERAL HOME   |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |
| Brudzinski Funeral Home PA 1407 Old Eastern Ave   |  |  |   |  |  |  |   |                         |  |   |                 |   |                 |                                  |  |

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the smooth operation of any business and for the protection of its interests.

2. The second part of the document describes the various methods used to collect and analyze data. It highlights the need for a systematic approach to data collection and the importance of using reliable sources of information.

3. The third part of the document discusses the challenges faced by businesses in the modern market. It identifies the key factors that can lead to success or failure and provides practical advice on how to overcome these challenges.

4. The fourth part of the document describes the various methods used to collect and analyze data. It highlights the need for a systematic approach to data collection and the importance of using reliable sources of information.

5. The fifth part of the document discusses the challenges faced by businesses in the modern market. It identifies the key factors that can lead to success or failure and provides practical advice on how to overcome these challenges.

6. The sixth part of the document describes the various methods used to collect and analyze data. It highlights the need for a systematic approach to data collection and the importance of using reliable sources of information.

7. The seventh part of the document discusses the challenges faced by businesses in the modern market. It identifies the key factors that can lead to success or failure and provides practical advice on how to overcome these challenges.

8. The eighth part of the document describes the various methods used to collect and analyze data. It highlights the need for a systematic approach to data collection and the importance of using reliable sources of information.

9. The ninth part of the document discusses the challenges faced by businesses in the modern market. It identifies the key factors that can lead to success or failure and provides practical advice on how to overcome these challenges.

10. The tenth part of the document describes the various methods used to collect and analyze data. It highlights the need for a systematic approach to data collection and the importance of using reliable sources of information.

00-01483

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 7 3

REG. NO.

|   |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>HATTIE P. NULL.</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>3-17-86</b> |   |  | 2b. HOUR <b>8:00 PM</b>  |  |   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>C</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>3 16 97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.                      |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. General Hosp.</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MAJORITY OF WORKING YEAR) <b>homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>   |  |
| 13a. USUAL RESIDENCE (IF HUSBAND, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Carroll</b> 13c. CITY OR TOWN <b>Westminster</b>   |  |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE <b>30 Locust House 21157</b>                        |  |   |  |
| 14. FATHER'S NAME <b>Lewis D. G. Wantz</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME <b>Mary Alice Lookingbill</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO. <b>na</b>  |   | 17. INFORMANT <b>C. Clifton/Null, North Pt. Blvd. 21219</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>- Cordovary artery Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>- Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>   |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-3-86</b> 19 <b>86</b> to <b>3/17/86</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>3-17</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE <b>L. Leidy</b>  |  |   |   | DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  |  |  | 22c. DATE SIGNED <b>3/17/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RUBEN REIDER M.D.</b>  |  |   |   | 22e. ADDRESS <b>914 N. Charles Street Baltimore MD 21202</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>3/20/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Carroll MD</b>              |  |   |  |
| 24. FUNERAL DIRECTOR <b>412 Washington Road Robert K. Pritts, Sr., Westminster, MD.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE <b>John D. ...</b>                                      |  |   |  |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the funeral transit permit. Then please remove carbon copy of this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-01403

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00-016191

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 7 4

REG. NO.

|  |  |   |   |   |                            |  |  |
|--|--|---|---|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MORTON MIDDLE LAST NUSBAUM  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR 3, 21 86                |   |                            | 2b. HOUR<br>03.45 A.M.   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR JANUARY 1, 1902  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. COUNTY GENERAL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PROPRIETOR  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br>DEPT. STORE   |  |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>BALTO.                                       |   | 13c. CITY OR TOWN<br>BALTO |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST JACOB NUSBAUM   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST HANNAH MARKEL |   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNKNOWN  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>226-10-7845A   |   | 17. INFORMANT<br>ADDRESS UNIT 6 (21208)<br>MRS. ELIZABETH EPSTEIN 2A STONEHENGE CIR.  |                            |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Obstructed Hepatitis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>26 days</u>  |  |   |   |   |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |   |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/23</u> , 19 <u>86</u> , to <u>3/21</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/21</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |   |   |   |                            |  |  |
| 22b. SIGNATURE<br><u>Young J. R.</u>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                            | 22c. DATE SIGNED<br>3/21/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Young J. R. M.D.</u>   |  |   |   | 22e. ADDRESS<br><u>B. C. G. H.</u>  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>3/23/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW CEM  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO MD   |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>SELLEVINSON</u><br>ADDRESS <u>6010 REISTERSTOWN RD</u><br><u>BALTIMORE, MARYLAND 21215</u>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 27 1986  |                            | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rendell</u>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-01310

20% COTTON WISES

DAVID L. HARRIS



21.12.1950  
The following is a list of the names of the persons who have been named in the above mentioned document.

070021

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 7 5

REG. NO.

|  |  |  |  |   |  |  |   |  |   |  |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARETHE S. OAKLEY</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 3, 1986</b>            |   |  | 2b. HOUR<br>M  |   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 19, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><b>79</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Ruxton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6512 Darnall Rd.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Ruxton</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6512 Darnall Rd. 21006</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William D. Stalfort</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Thekla Imwold</b>  |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-38-1557</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Gordon Flautt -315 Investment Bldg., 21204</b>   |  |  |   |  |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>ALT. heart disease</u>  |  |  |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>9/25/85</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT.</u> 19 <u>85</u> to <u>OCT.</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>OCT.</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Dr. G. William Benedict</u>   |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>3/4/86</u>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. G. William Benedict</b>  |  |  | 22e. ADDRESS<br><b>2 W. University Pkwy., Balto., Md.</b>              |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-5-86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto., Md.</b>  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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CECIL CULLUM ENGINE





065022

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George E. PEDDICORD SR.   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 3, 1986  |  | 2b. HOUR<br>9:50 P M  |   |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug: 21, 1907 AR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78<br>YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD   |   |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Sq. Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Degreaser   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel Mill   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Essex  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Norman Peddicord   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-   |  | 17. INFORMANT<br>ADDRESS<br>Eva E. Peddicord, Wife Same   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Septic Shock</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Urinary Tract Infection and Infected Decubiti</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (he/she) attended the deceased from <u>February 11</u> , 19 <u>86</u> , to <u>March 3</u> , 19 <u>86</u> , that (he/she) saw the deceased alive on <u>March 3</u> , 19 <u>86</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (he/she) (did/did not) view the body after death.  |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><u>G. Sloan</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>3/3/86</u>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. Sloan, M.D.  |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/2/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |   |
| 24. FUNERAL DIRECTOR<br><u>Epuzdzinski Funeral Home PA 1407</u>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 4 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-01271

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |   |   |
|---|--|---|--|---|--|--|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>DOROTHY M. PERRY   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03 21 '86                                     |  | 2b. HOUR<br>1:40P M   |   |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOVEMBER 22, 1924   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>61 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                        |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>TIMONIUM  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LESTER  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>PERAL LAY  |  | 13e. STREET ADDRESS / ZIP CODE<br>206 BURNING TREE ROAD 21093                        |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218 22 1750  |  | 17. INFORMANT<br>ADDRESS<br>THURSTON R. PERRY SAME AS #13e  |  |  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br>renal failure |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 3/14, 19 86, to 3/21, 19 86, that (I) (we) last saw the deceased alive on 3/21, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |   |
| 22b. SIGNATURE<br>Michael A. Smith, M.D.  |  |   |  | DEGREE<br>MD  |  |  |  | 22c. DATE SIGNED  |   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL A. SMITH, M.D.   |  |   |  | 22e. ADDRESS<br>GBMC - 6701 N. CHARLES STREET 21204   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>25MARCH86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. PAUL'S LUTH. CEMETERY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ABERDEEN, HARFORD COUNTY, MD.          |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 24 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>Lidia Davidson-Rodriguez                               |  |   |   |

MEDICAL CERTIFICATION

9/2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of Pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be satisfied of one of the following:

BP

17510-0

2000 COLLOID

2000 COLLOID



00-00111

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |  |                             |  |
|--|--|--|--|--|-----------------------------|--|
| 2 DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE JOSEPH PFANNENSTEIN</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 12 1986</b> |  | 2b HOUR<br><b>7:20 A.M.</b> |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUGUST 21, 1916</b>                                    |                             |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                             |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |  |                             |  |
| 10 CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>GUARD</b>                |                             |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>DEPARTMENT STORE</b>  |  | 13a STATE<br><b>MARYLAND</b>   |  |  |                             |  |
| 13b COUNTY<br><b>BALTIMORE</b>   |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN PFANNENSTEIN</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA KNISPEL</b>  |  |  |                             |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>KOREAN 249 64 0970</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>                      |                             |  |

|  |  |   |
|--|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>MINUTES</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE RENAL FAILURE</b>   |  | <b>2 DAYS</b>   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>SEPTICEMIA</b>  |  | <b>2 DAYS</b>   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **COPD, ASCVD**

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>JANUARY 13, 1986</b> , to <b>MARCH 12, 1986</b> , that (I) (we) last saw the deceased alive on <b>MARCH 12, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b SIGNATURE<br><i>Peter V. Juvan</i>  |  |   |  | DEGREE  |  | 22c DATE SIGNED<br><b>3-12-86</b>   |  |
| 22e PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER V. JUVAN, M.D.</b>   |  |   |  | 22e ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>                      |  |   |  |

|   |  |                              |  |   |  |  |  |
|---|--|------------------------------|--|---|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>       |  | 23b DATE<br><b>3/14/1986</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH CEM.</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>DIPPEL FUNERAL HOMES INC.</b> |  |                              |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 13 1986</b>                |  |  |  |
| 25b REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>       |  |                              |  | 26 BELAIR ROAD BALTIMORE MARYLAND 21206                           |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers, place 1 and 2 in the envelope and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



065026

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRMA ELIZABETH PFEFFER</b>                 |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 - 2 - 86</b>  |  |   |  | 2b. HOUR<br><b>8:05 P</b> M                                      |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 9 28</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto</b>                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County MD</b>                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson md</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris Hospice</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical</b>              |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>220 Chantrey Road 21093</b> |  |
| 4. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Milton Pfeffer</b>              |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Elizabeth Smith</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-24-8321</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mildred A. Pfeffer 220 Chantrey Road 21093</b>                   |  |  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>BRAIN TUMOR</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-24</b> , 19 <b>85</b> , to <b>3/2</b> , 19 <b>86</b> , that (I) (we) last<br>saw the deceased alive on <b>3/2</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-2-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Tsakchi</b>   |  |  |  | 22e. ADDRESS<br><b>2300 Delaney Valley Rd.<br/>Stella Maris Hospice</b>  |  |   |  |

|   |  |                            |  |  |  |   |  |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial.</b>                              |  | 23b. DATE<br><b>3-6-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1986</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



083028

TIME 11:00 AM



STATION 1000

1000



NOT TO BE USED

1000

1000

1000

1000



00-01805

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be circulated within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be buried with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                            |  |  |
|--|--|--|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Wilmer Edward PIPINO</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>March 26, 1986</b>        |   | 2b. HOUR<br><b>12:45aM</b> |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-24-1910</b>  |                            | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>75</b><br>YRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville MD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Surveyor-Ret.</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Arundel Corp</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>MD Baltimore City</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>155 N. Linwood Ave. Balto. 21224</b>   |                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Pipino</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kathleen</b> |   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-9344</b>   |  | 17. INFORMANT ADDRESS<br><b>Mary B. Gunzman, 155 N. Linwood Ave. Baltimore, Maryland 21224</b>  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Chronic Obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |   |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>Congestive Heart Failure, Brainstem Infarction</b>   |  |  |  |   |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 6</b> , 19 <b>86</b> , to <b>March 26</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>March 26</b> , 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |  |  |   |                            |  |  |
| 22b. SIGNATURE<br><b>Larry Smith</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |                            | 22c. DATE SIGNED<br><b>3/26/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Larry Smith, M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |  |   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-29-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller, Inc., 6415 Belair Rd. 21206</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>   |                            | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |

BP

19/09/76

Handwritten signature or initials

071161

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                 |   |  |
|--|-----------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LOUIS I. PLACK SR.  |                 | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH 3 DAY 8 YEAR 1986 HOUR 11 PM  |  |
| 3. SEX<br>Male   | 4. RACE<br>CAUC | 5. DATE OF BIRTH<br>MONTH 7 DAY 27 YEAR 1983  | 6. AGE IN YEARS<br>LAST BIRTHDAY 82 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 8. CITY OR TOWN OF DEATH<br>Catonsville  |                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>COUNTY Baltimore MD   |  |
| 10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>10a. STATE Maryland 10b. COUNTY Baltimore 10c. CITY OR TOWN Catonsville  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6537 Redgate Circle Catonsville |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Representative  |                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>B.G. & E.  |  |
| 13a. STREET ADDRESS<br>6537 Redgate Circle Catonsville   |                 | 13b. CITY OR TOWN<br>Md. 21228  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Plack   |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Flynn  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |                 | 16b. SOCIAL SECURITY NO.<br>212-05-3148   |  |
| 17. INFORMANT<br>Catherine Plack Same as 13c.  |                 | ADDRESS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) CARCINOMA HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YRS                   |                 |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>NONE  |                 |   |  |
| 19a. DATE OF OPERATION   |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                 |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                 |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                 |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                 |   |  |
| ACTUAL SIGNATURE<br>John R. Steinberg MD   |                 | TITLE (SPECIFY)<br>M.D. DEPUTY MEDICAL EXAMINER   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>JOHN R. STEINBERG  |                 | DATE SIGNED<br>3/8/86   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                 | 23b. DATE<br>3/11/86  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery   |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy M. & Russell C. Witzke Funeral Home  |                 | 25a. DATE REC'D. BY REGISTRAR<br>MAR 10 1986  |  |
|  |                 | 25b. REGISTRAR'S SIGNATURE<br>Gina Davidson-Randall   |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |                                   |   |  |
|---|--|--|--|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MABEL POE</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 25, 1986</b> |   | 2b. HOUR<br><b>2:10 P.M.</b>   |  |                                   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 21, 1929</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b><br>YRS. MONTHS DAYS HOURS MIN.  |                                   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO. CO. MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CO. MD.</b>   |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>REISTERSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>314 E. CHERRY HILL RD.</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED NURSE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>REISTERSTOWN</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                                   | 13e. STREET ADDRESS / ZIP CODE<br><b>314 E. CHERRY HILL RD. 21136</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANDREW J. POE</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETHEL ROGERS</b>  |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-32-7991</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MR. EDGAR A. POE OWINGS MILLS, MD.</b>   |  |  |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intractable Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Aortic Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |                                   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-15-1985</b> , to <b>3-25-1986</b> , that (I) (we) lost saw the deceased <b>above</b> , (I) (we) (did) (did not) view the body after death. <b>3-19-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |  |  |   |  |  |                                   |   |  |
| 22b. SIGNATURE<br><b>Quasar V. Cavano</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>3-26-86</b>   |                                   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Quasar V. Cavano</b>  |  |  |  | 22e. ADDRESS<br><b>5310 Old Et Rd</b>   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>MAR. 27, 86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MAYS CHAPEL</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LUTHERVILLE, MD.</b>  |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ELINE FUNERAL HOME</b>   |  |  |  | ADDRESS<br><b>REISTERSTOWN, MD.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>  |                                   |   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |                                   |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MD.

11-18-1918

WHEAT, RICHARD

1918

11-18-1918

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11-18-1918

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or initialed as follows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |  |   |   |  |  |
|---|--|---|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <b>ARTHUR</b> MIDDLE <b>J.</b> LAST <b>POKORNY</b><br><i>ARTHUR J. POKORNY</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 29 86</b>                        |   |   | 2b. HOUR<br><b>7<sup>00</sup> A</b><br>M   |   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 22 12</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                    |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4 Lyn Court</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Controller- Admiral Pontiac</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Lutherville</b>                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>4 Lyn Court 21093</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Pokorny</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Antonette Friedel</b> |   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>WW II 212-01-5994</b>                      |   | 17. INFORMANT ADDRESS<br><b>Dorothy E. Pokorny - Same as #13e</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ADENOCARCINOMA of The Bowel</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>EMETS TO LIVER.</b><br>(c) <b>1983</b>       |  |   |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>10 MIN.</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>  |  |   |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Joyce Y. Gross</i>   |  |   |   |   |   | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>3/31/86</b>  |  |  |
| 22d. PHYSICIAN'S NAME, (TYPE OR PRINT)<br><b>Joyce Y. Gross</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>3900 Loch Raven Blvd Balto., Md</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>4-1-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto., Md.</b>                  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |

BP







00-00284

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                                  |  |  |
|--|--|---|--|---|----------------------------------|--|--|
| 1 DECEASED NAME<br>(TYPE COMPLETE)<br>FIRST MIDDLE LAST<br><b>ANTHONY POLESKI</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 11, 1986</b> |   | 2b. HOUR<br>A. M.<br><b>5:00</b> |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 22, 1912</b>  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>73</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Timonium</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11700 RUTLEDGE ROAD</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LONG SHOREMAN</b>  |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LOCAL 839</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MICHAEL POLESKI</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA PYRYNAS</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>11700 RUTLEDGE ROAD 21093</b>  |                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.II 218 03 4852</b>  |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>  |                                  | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE PARKINSON'S DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |  |   |                                  |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |                                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1979</b> , 19____, to <b>3-11</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>3-10</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |   |  |   |                                  |  |  |
| 22b. SIGNATURE<br><b>DR. BA YIN OUNG</b>   |  |   |  | DEGREE  |                                  | 22c. DATE SIGNED<br><b>MARCH 13, 1986</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. BA YIN OUNG</b>  |  |   |  | 22e. ADDRESS<br><b>8022 BELAIR ROAD</b>   |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MARCH 15, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILL</b>   |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPLAIN OF MEMORIES</b>  |  |   |  | ADDRESS<br><b>8800 ROAD HARFORD</b>   |                                  | 25a. DATE REC'D. BY REGISTRAR / 25b. REGISTRAR'S SIGNATURE<br><b>MAR 14 1986</b>   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



070020

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |   |  |  |  |  |                               |  |
|--|--|---|--|--|---|--|--|--|--|-------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mark H Porter</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 6 1986</b> |  | 2b. HOUR<br><b>5:15 PM</b>  |  |  |  |  |                               |  |
| 1.5 SEX<br><b>male</b>   |  | 4 RACE<br><b>White</b>  |  | 3. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 20 1912</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  | IF UNDER 74 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE / STATE OR FOREIGN COUNTRY<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Saint Joseph Hospital</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Stationary Engineer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Ret.</b> |  |                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Maryland</b> 13c. CITY OR TOWN <b>Baltimore</b>  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3413 Keene Avenue 21214</b>                               |  |  |  |                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Victor S. Porter</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leila Harrison</b>   |   |  |  |  |  |                               |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-9026</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Kathleen R. Porter 3413 Keene Ave. 21214</b>  |   |  |  |  |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Fibrosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROPRIATE INTERVAL BETWEEN CAUSE AND DEATH |  |   |  |  |   |  |  |  |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>Pneumonia</b>   |  |   |  |  |   |  |  |  |  |                               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |  |  |  |                               |  |
| 22b. SIGNATURE<br><b>Beatrice P. Dinger, M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |   |  |  | 22c. DATE SIGNED<br><b>3/6/86</b>                |  |                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |   |  |  |  |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Mar 10 1986</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                        |  |  |  |                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |  |   |  | ADDRESS<br><b>Baltimore, Maryland</b>  |   | 25. DIRECTED BY (TYPE OR PRINT) SIGNATURE<br><b>Mar 7 1986</b>                                 |  |  |  |                               |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 would be kept with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, no medical examiner is required.

070020

U.S.A.

U.S.A.

THE SECRETARY OF DEFENSE

2015 Avenue Avenue 1111

Washington

1 - 10 - 1951

Washington, D.C. 20301

Secretary of Defense, Department of Defense, Washington, D.C. 20301

064056

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RUSSELL</b> MIDDLE <b>POTTEIGER</b><br><i>Russell LEVI Potteiger</i>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 1 86</b>  |   | 2b. HOUR<br><b>3 40</b> A M  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11/20/1894</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Sp. Pt., Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Heritage Nursing Ctr.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>1st Heater</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Mfrgr.</b> |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Dundalk</b>  |  |   |   |  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>32 Broadship Rd. 21222</b>   |   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Levi</b> MIDDLE <b>Potteiger</b> LAST <b>UNKNOWN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(TYPE OF SERVICE OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213.07.6668</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Jack R. Potteiger (Son) (Same as 13e)</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>2° viral infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Theodore C. Patterson, M.D.</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>3/1/1986</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THEODORE C. PATTERSON, M.D.</b>   |  | 22e. ADDRESS<br><b>3427 Dundalk Ave., Dundalk, Md. 21222</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>3/3/1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b>                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc., Dundalk, Md. 21222</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 3 1986</b>  |   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |   |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

20% COTTON LITE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Anna Barbara POWELL   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 7, 1986                   |   |  | 2b. HOUR<br>2:05a M  |   |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 17 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaking  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>1241 Hilldale Rd. 21237 |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Sebour  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Caroline Appel        |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-48-7248 |   | 17. INFORMANT<br>ADDRESS<br>Daniel C. Powell 1241 Hilldale Rd. 21237                     |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 26, 1986, to March 7, 1986, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 7, 1986, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>Kay C. Kitchen M.D.  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>3-7-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kay C. Kitchen, M.D.  |  |   |  |   |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>3-10-86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lorraine F. H. 7401 Belair Rd  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 10 1986   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
(IMPORTANT!) If item 21 is marked or has 18 shown any injury, or other traumatic event, the medical examiner must be notified at once.



1. The purpose of this document is to provide information regarding the use of the system.

2. The system is designed to provide a secure and reliable method of communication.

3. The system is capable of handling a large volume of data and is designed to be flexible and adaptable.

4. The system is designed to be easy to use and to provide a high level of security.

5. The system is designed to be reliable and to provide a high level of performance.

6. The system is designed to be secure and to provide a high level of protection.

7. The system is designed to be flexible and to provide a high level of adaptability.

8. The system is designed to be easy to use and to provide a high level of security.

9. The system is designed to be reliable and to provide a high level of performance.

10. The system is designed to be secure and to provide a high level of protection.



00-02153

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. CERTIFICATE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |                                |   |  |  |  | REG. NO.   |  |
|--|-------------------------|---|--|---|--------------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CHRISTIAN LEWIS PRICE</b>  |                         |   |  |   |                                |   |  |  |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 3 16 86 |  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUC.</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 17 20</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>66</b> YRS.                     | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>3 27 86</b>                                    |  | 2d. HOUR<br><b>3:10 P.M.</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2906-C Liberty Parkway</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mill Wright</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>                          |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>DUNDALK, MD 21222</b><br><b>2906-C LIBERTY PARKWAY</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George M. Price</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Lee Smith</b> |   |                                | 16. ADDRESS<br><b>412 E. Lee Street</b><br><b>Blacksburg, Va. 24060</b>                         |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Mabel P. Lucas</b>  |                                | 17. ADDRESS<br><b>Blacksburg, Va. 24060</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>UNKNOWN CAUSES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                         |   |  |   |                                |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                         |   |  |   |                                |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |                         |   |  |   |                                |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>J M Niehoff</b>   |                         |   |  | TITLE (SPECIFY)<br>M.D.   |                                |   |  | DATE SIGNED<br><b>3/27/86</b>  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>J M NIEHOFF, MD</b>   |                         |   |  | ADDRESS<br><b>6800 MORNINGTON RD. BALTO, MD 21222</b>   |                                |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         |   |  | 23b. DATE<br><b>3/30/1986</b>   |                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Blacksburg Virginia</b>         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>   |                         |   |  |   |                                | ADDRESS<br><b>7922 Wise Avenue Dundalk, Maryland 21222</b>                                      |  | 25a. DATE REC'D BY REGISTRAR<br><b>APR 02 1986</b>                               |  |  |  |

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PRICE

LEVELS

1 17 20 22

2100 2 1000 1000 1000



00-01635

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |  |  |   |  |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARGARET B. PUGH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 25 86</b> |   |  | 2b. HOUR<br><b>4:20 AM</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 8 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>72</b> YRS.  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>   |  | 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Inglebrook Nursing Home</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Order Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Montgomery Ward</b>   |  | 13a. STREET ADDRESS / ZIP CODE<br><b>1300 Frances Avenue 21227</b>   |  | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George T. Dewling</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma B. Butler</b>                 |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-9529</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Walter Pugh 1300 Frances Ave. 21227</b>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Advanced arteriosclerotic CVD</b><br>(c) <b>Due to, or as a consequence of</b> |  |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Multiple CVA @ C of colon, visited 2 yrs ago</b>   |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                       |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/27 1985</b>                   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5404 East Drive 21227</b>   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/27 1985</b> to <b>3/25 1986</b> , that (I) (we) last saw the deceased alive on <b>3/25 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated herein. (If (we) did not view the body after death, so state.)                    |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Herbert J. Levickas MD</b>  |  |  |   | 22c. ADDRESS<br><b>5404 East Drive 21227</b>  |  |  |  | 22d. DATE SIGNED<br><b>3/25/86</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Herbert J. Levickas</b>  |  |  |   | 22f. ADDRESS<br><b>5404 East Drive 21227</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/27/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge Howard Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>She Davidson-Randall</b>  |  |   |  |

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER

1/20



00-00276

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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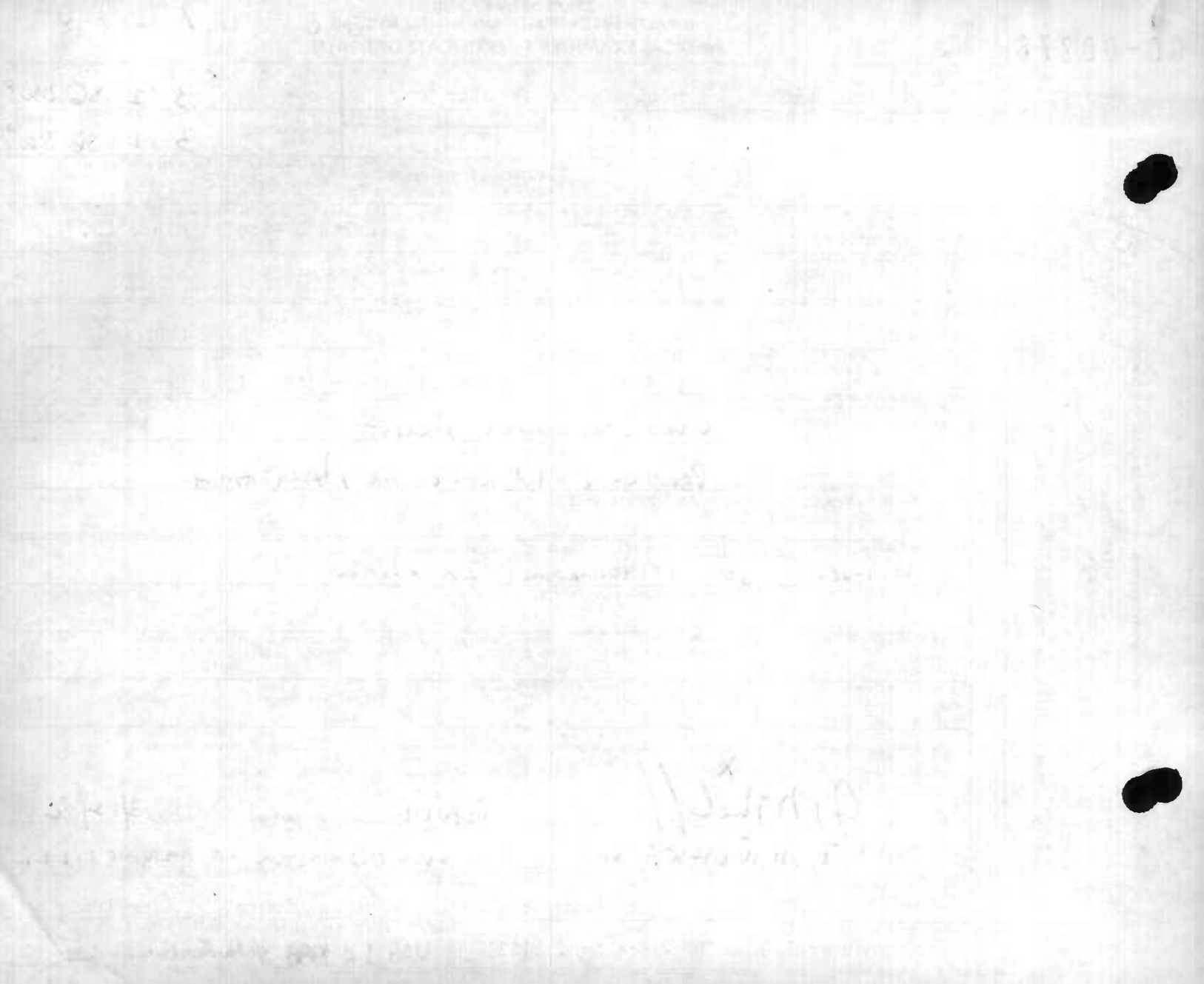
DHMH - 17  
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |         |  |        |   |                               |   |   |                                      |                                |         |   |
|---|---------|--|--------|---|-------------------------------|---|---|--------------------------------------|--------------------------------|---------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  | MIDDLE | LAST  | 2a. DATE KNOWN<br>OF DEATH    |   | ESTIMATED<br><input checked="" type="checkbox"/> MATED <input type="checkbox"/> | MONTH                                | DAY                            | YEAR    | 2b. HOUR<br>M                                   |
| Frederick Wendel Quaster Sr.  |         |  |        |   | 3 12 1986                     |   |   |                                      |                                |         | 2:30 P  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |        | 6. AGE (IN YEARS<br>LAST BIRTHDAY)  | IF UNDER 1 YR.<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN   |                                      | 7c. DATE<br>PRONOUNCED<br>DEAD |         | 2d. HOUR<br>M                                   |
| Male  | White   | Oct. 25 1937   |        | 48 YRS.   |                               |   |   |                                      | 3 12 1986                      |         | 3:00 P  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MD.   |   |                                      |                                |         |   |
| Maryland  |         | USA  |        |   |                               | Baltimore County  |   |                                      |                                |         |   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY |                                |         |   |
| Bowleys Quarters  |         | 1426 Burke Road  |        |   |                               | Salesman-Caplan Glass Co.   |   |                                      |                                |         |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         |  |        |   |                               |   |   |                                      |                                |         |   |
| 13a. STATE  |         | 13b. CITY  |        | 13c. CITY OR TOWN   |                               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS                  |                                |         |   |
| Md.   |         | Balto.   |        | Bowleys Quarters  |                               |   |   | 1426 Burke Road 21220                |                                |         |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |         |  |        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |                               |   |   |                                      |                                |         |   |
| Frederick Quaster   |         |  |        | Betty UNKNOWN   |                               |   |   |                                      |                                |         |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         |  |        | 16b. SOCIAL SECURITY NO.  |                               | 17. INFORMANT ADDRESS   |   |                                      |                                |         |   |
| no  |         |  |        | 219-26-8098   |                               | Mary Stansbury 1426 Burke Road 21220  |   |                                      |                                |         |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>PROBABLE VENTRICULAR ARRHYTHMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |  |        |   |                               |   |   |                                      |                                |         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>HISTORY OF MYOCARDIAL INFARCTION</u>  |         |  |        |   |                               |   |   |                                      |                                |         |   |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |        |   |                               |   |   |                                      |                                |         |   |
|   |         |  |        |   |                               |   |   |                                      |                                |         |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |   |   |                                      |                                |         |   |
|   |         |  |        |   |                               |   |   |                                      |                                |         |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |        | 21f. LOCATION<br>STREET   |                               | CITY OR TOWN  |   | COUNTY                               |                                | STATE   |   |
|   |         |  |        |   |                               |   |   |                                      |                                |         |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |        |   |                               |   |   |                                      |                                |         |   |
| ACTUAL<br>SIGNATURE   |         | TITLE (SPECIFY)<br>M.D. DEPUTY   |        |   |                               | MEDICAL EXAMINER  |   | DATE<br>SIGNED                       |                                | 3/14/86 |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | J. M. NIEMETZ, MD  |        |   |                               | ADDRESS   |   | 6500 MORNINGTON RD BALTO MD 21222    |                                |         |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                               | 23d. LOCATION<br>CITY OR TOWN   |   | COUNTY                               |                                | STATE   |   |
| Burial  |         | 3/15/86  |        | Oak Lawn Cemetery   |                               | Baltimore   |   | Maryland                             |                                |         |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |         |  |        |   |                               | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE           |                                |         |   |
| Connolly Funeral Home 300 Mace Ave. 21221   |         |  |        |   |                               | MAR 14 1986   |   | John Davidson-Randall                |                                |         |   |



00577

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEE</b>  |  | FIRST<br><b>LEE</b>  |  | MIDDLE<br><b>RABINEAU</b>   |  | LAST<br><b>RABINEAU</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 15, 1986</b>   |  | 2b. HOUR A.<br><b>5:30</b> M.                                |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 19, 1916</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1 HIGH STEPPER CT., APT. 205</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b>                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>JEWELRY STORE</b>    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1 HIGH STEPPER CT., APT. 205</b>  |  | #21208   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH GOLDBLATT</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE PATZ</b>   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-09-8236</b>  |  | 17. INFORMANT<br><b>SYLVAN RABINEAU APT. 205</b><br><b>1 HIGH STEPPER CT. BALTO., MD 21208</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic breast carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 years</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7/85 35 3/14 86</b>   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/85</u> 19 <u>35</u> to <u>3/14</u> 19 <u>86</u> that (I) (we) lost<br>saw the deceased alive on <u>3/14</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                             |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Ruth Kantor MD</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>3/15/86</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUTH KANTOR, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>22 S. GREENE ST. BALTO., MD</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MAR. 16, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BETH ISAAC ADATH ISRAEL</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Gina Davidson-Randall</u>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP

1917

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00-01197

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |        |                                    |  |                                  |                                   |   |  |  |
|--|--------|------------------------------------|--|----------------------------------|-----------------------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        |                                    | 2a. DATE KNOWN OF DEATH  |                                  |                                   | 2b. HOUR  |  |  |
| FIRST MIDDLE LAST<br>Jack David Reechel  |        |                                    | MONTH DAY YEAR<br>March 21/19 86   |                                  |                                   | M   |  |  |
| 3 SEX  | 4 RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR | 6. AGE (IN YEARS<br>LAST BIRTHDAY)   | 7. IF UNDER 1 YR.<br>MONTHS DAYS | 8. IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD  |  |  |
| Male   | White  | July 14 1939                       | 46 YRS.  |                                  |                                   | March / 21/19 86  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |        |                                    | 7b. CITIZEN OF WHAT COUNTRY?   |                                  |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |
| Maryland   |        |                                    | USA  |                                  |                                   | Baltimore County, MD.   |  |  |
| 11. CITY OR TOWN OF DEATH  |        |                                    | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                  |                                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  |
| Dundalk  |        |                                    | First Street Marine Terminal   |                                  |                                   | Long Shoreman   |  |  |
| 13a. STATE   |        |                                    | 13b. CITY OR TOWN  |                                  |                                   | 13c. STREET ADDRESS   |  |  |
| Maryland   |        |                                    | A A Co. Glen Burnie  |                                  |                                   | 415 N. Crain Highway 21061  |  |  |
| 15. FATHER'S NAME<br>FIRST MIDDLE LAST   |        |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                                  |                                   | 17. INFORMANT ADDRESS   |  |  |
| Otto Reechel   |        |                                    | Iva L. Pumphrey  |                                  |                                   | Mrs. Patricia M. Reechel Same as 13   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |        |                                    | 16b. SOCIAL SECURITY NO.   |                                  |                                   | 17. INFORMANT ADDRESS   |  |  |
| Yes  |        |                                    | July 24, 1957  |                                  |                                   | 218.36.3776   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:   |        |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                  |                                   |   |  |  |
| IMMEDIATE CAUSE (a) _____<br>8259 Mechanical Asphyxia<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |        |                                    |  |                                  |                                   |   |  |  |
| (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |        |                                    |  |                                  |                                   |   |  |  |
| (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |        |                                    |  |                                  |                                   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |        |                                    |  |                                  |                                   |   |  |  |
| 19a. DATE OF OPERATION   |        |                                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                  |                                   | 20. AUTOPSY?  |  |  |
|  |        |                                    |  |                                  |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |        |                                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |                                  |                                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |
|  |        |                                    | 10:55 PM 3/ 21/1986  |                                  |                                   | subject pinned in cab of truck  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |        |                                    | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                  |                                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |
|  |        |                                    | terminal   |                                  |                                   | 1st. Street, Lot 1601, Dundalk, Balto. Co., Md.                               |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |        |                                    |  |                                  |                                   |   |  |  |
| ACTUAL SIGNATURE   |        |                                    | TITLE (SPECIFY)  |                                  |                                   | DATE SIGNED   |  |  |
|  |        |                                    | M.D. Assistant MEDICAL EXAMINER  |                                  |                                   | 3/22/86   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |        |                                    | ADDRESS  |                                  |                                   |   |  |  |
| Gregory R. Kauffman, M.D.  |        |                                    | 111 Penn St.   |                                  |                                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |        |                                    | 23b. DATE  |                                  |                                   | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| Burial   |        |                                    | March 25, 1986   |                                  |                                   | Glen Haven Mem. Park  |  |  |
| 24. FUNERAL DIRECTOR NAME  |        |                                    | 25a. DATE REC'D. BY REGISTRAR  |                                  |                                   | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Singleton Funeral Home   |        |                                    | MAR 24 1986  |                                  |                                   | John Davidson Hordell   |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M

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DHMH - 17  
(VR A15 ME (5))

DATE NOV 10 1963

DAVID M. H. H. H.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |                           |  |
|--|--|---|--|--|---------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>HAZEL BRACE REED</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 1, 1986</b> |  | 2b HOUR<br><b>1:00A</b> M |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 21, 1889</b>                                      |                           |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b>  |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                           |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Owings Mills</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baptist Home of Maryland</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |                           |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  | 13a STREET ADDRESS / ZIP CODE<br><b>10729 Park Heights Avenue 21117</b>   |  |  |                           |  |
| 13b STATE<br><b>Maryland</b>   |  | 13c CITY OR TOWN<br><b>Owings Mills</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer Brace</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Adaline Clark</b>  |  |  |                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>214-54-4978</b>   |  | 17 INFORMANT ADDRESS<br><b>Baptist Home 10729 Park Heights Ave. 21117</b>                      |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>PERIPHERAL VASCULAR DISEASE / RENAL INSUFFICIENCY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>PERIPHERAL VASCULAR DISEASE / RENAL INSUFFICIENCY</b>  |  |   |  |  |                           |  |
| 19a DATE OF OPERATION<br><b>---</b>  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                           |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. --- 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>---</b>    |                           |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>---</b>   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>---</b>                                 |                           |  |
| 22a I certify that (I) (the hospital) attended the deceased from <b>FEB 27</b> 19 <b>86</b> to <b>MARCH 1</b> 19 <b>86</b> that (I) last saw the deceased alive on <b>FEB 27</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |  |                           |  |
| 22b SIGNATURE<br><b>John G. Lavin</b>  |  | DEGREE<br><b>MD</b>   |  | 22c DATE SIGNED<br><b>3-3-86</b>   |                           |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John G. Lavin</b>   |  | 22e ADDRESS<br><b>6805 York Road 21212</b>  |  |  |                           |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>3-5-86</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |                           |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elmira Channing New York</b>   |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>  |  |  |                           |  |
| 25a DATE REC'D. BY REGISTRAR<br><b>MAR 4 1986</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |  |                           |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and 3 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 should also be marked.

BP



00-01384

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon papers. Page 1 must be filed with the 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Hilda S. Reich  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 15, 1986   |  | 2b. HOUR<br>6:15 p.m.  |
| 3. SEX<br>Female  | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 25, 1901  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1924 Powers Lane 21228 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Maryland  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Catonsville  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1924 Powers Lane 21228                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John E. Streit  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Christianna Hettinger  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |   | 17. INFORMANT<br>ADDRESS<br>William E. Reich Same as # 13                            |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brain stem stroke</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Dissecting aortic aneurysm 6 days</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary artery disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>unknown</u> |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Cause of death listed here is in medical records</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> 19 <u>68</u> to <u>3/15</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Cliff Ratliff Jr.</u>  |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   | 22c. DATE SIGNED<br>03/17/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Cliff Ratliff Jr., M.D.  |   | 22e. ADDRESS<br>5772 Westview Mall Balto., MD 21228   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>03/19/86   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Mem. Pk.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Sykesville, Carroll, MD                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MacNabb Funeral Home  |   | ADDRESS<br>Catonsville, MD  |   | 25a. DATE REC'D. BY REGISTRAR<br>03/16/86  |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Gina Davidson-Randall</u>  |   |  |  |

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(Type or print) <b>FLORENCE A. REISER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 6, 1986</b>                                     |   | 2b. HOUR<br>A. <b>7:30 M.</b>  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 8, 1907</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS                          | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>       |  |
| 10. CITY OR TOWN OF DEATH<br><b>PARKVILLE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2811 2nd AVE.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b>              | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>PARKVILLE</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2811 2nd AVE. 21234</b>              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Mac Kenzie</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET J. Mac Kenzie</b>                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>212252462</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line form. If under PART I, DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTICEMIA, CANDIDA.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MURKLE, BILAT. RENAL CALCUL.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ALL PNEUMONIA.</b>   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ASCVD C.V.A.</b>   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-8-86</b> to <b>3-25-86</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>3-25-86</b> 19 <b>86</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> did not view the body after death. |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Ruben Sebastian, M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>MARCH 6, 1986</b>                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. RUBEN S. SEBASTIAN</b>   |   | 22e. ADDRESS<br><b>2314 EAST JOPPA ROAD</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>3-8-1986</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO Maryland</b>                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPEL OF MEMORIES HARFORD</b>  |   | 25a. DATE REG'D BY REGISTRAR<br><b>MAR 7 1986</b>   |   |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

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CERTIFICATE # 07096



00-00665

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |   |  |   |  |  |  |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANK RENAUT</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 16, 1986</b>              |   |   | 2b. HOUR<br>a<br><b>1:00</b><br>M  |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 19, 1925</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b><br>YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Pikesville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>805 Olmstead Road</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Corp. Treasurer</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Wholesale Books</b>  |  |  |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Pikesville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>805 Olmstead Rd., 21208</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry F. Renaut</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gladys Lucas</b>      |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>526 36 5323</b>                            |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Ruth E. Renaut, Same</b>                  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arterial Valve insufficiency, failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>months</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cerebral Vascular Disease - Stroke syndrome</b> |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a-<br><b>Arteriosclerotic Cerebral Vascular Disease - Stroke syndrome</b>  |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/1</b> , 19 <b>86</b> , to <b>3/16</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Philip H. Moore</b>  |  |   | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF<br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/17/86</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Philip Moore, MD</b>  |  |   | ADDRESS<br><b>3925 Beech Ave 21212 Johns Hopkins Hospital, Balto., MD</b> |   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>3/17/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1986</b>                           |  |   |  |  |  |
| 4905 York Road Balto., MD 21212   |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Carroll E. Henderson</b>                     |  |   |  |  |  |

MEDICAL CERTIFICATION

9876543210

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 must be completed.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. The first part of the report is a summary of the work done during the year. It is divided into two main sections: a general summary and a detailed account of the work done in each of the four departments. The general summary is given in the first section, and the detailed account is given in the second section. The general summary is given in the first section, and the detailed account is given in the second section. The general summary is given in the first section, and the detailed account is given in the second section.

The second part of the report is a detailed account of the work done in each of the four departments. It is divided into four sections, one for each department. The first section is for the Department of Agriculture, the second for the Department of Commerce, the third for the Department of Education, and the fourth for the Department of Health. Each section is divided into two parts: a general summary and a detailed account of the work done. The general summary is given in the first part, and the detailed account is given in the second part. The general summary is given in the first part, and the detailed account is given in the second part.

The third part of the report is a summary of the work done during the year. It is divided into two main sections: a general summary and a detailed account of the work done in each of the four departments. The general summary is given in the first section, and the detailed account is given in the second section. The general summary is given in the first section, and the detailed account is given in the second section. The general summary is given in the first section, and the detailed account is given in the second section.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please show carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 0 9 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                            |  |
|--|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Florence May Richmond</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 2, 1986</b> |   | 2b. HOUR<br><b>8:50a M</b> |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 1, 1893</b>                                     |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92 YRS</b>   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                            |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |   |   |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Ivy Hall Geriatric Center</b>           |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  | 13a. STATE<br><b>Maryland</b>   |   |   |                            |  |
| 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Essex</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>945 Martin Rd. 21221</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Benjamin Long</b>  |   |   |                            |  |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Stella Lehman</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO --</b>  |   |   |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>188 14 2374</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Willard J. Ford 253 Nanticoke Road Essex, Maryland 21221</b>   |   |   |                            |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory tract infection</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>7 yrs.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mth</b>                     |  |   |   |   |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>  |  |   |   |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |   |   |                            |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 24</b> , 19 <b>86</b> , to <b>Feb 28</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>Feb 28</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |   |   |                            |  |
| 22b. SIGNATURE<br><b>Louis O. Oksen</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>3/3/86</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LOUIS O. OKSEN</b>   |  | 22e. ADDRESS<br><b>1012 OLD NORTH PT RD 21224</b>   |   |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/5/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cemetery</b>                              |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County Maryland</b>   |  | 24. FUNERAL HOME<br>NAME ADDRESS<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.</b>  |   |   |                            |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Warden</b>  |   |   |                            |  |

March 1986 Florence Jay Richmond

White Mount 1, 1986

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, state any injury, or other traumatic event, the medical examiner will be notified.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |                            |  |
|---|--|---|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES Edwin Richardson</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 18 86</b> |  | 2b. HOUR<br><b>8:15 PM</b> |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 22 00</b>                                 |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN.<br><b>85 YRS.</b>          |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>B. County</b> MD                          |                            |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Francis Walter Richardson</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace Garlinger</b>   |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OF DATES)<br><b>WW 11 212 03 0129</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Mary Richardson 7830 Chelsea St. 21204</b>          |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RUPTURED AORTIC ANEURYSM</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |   |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>  |  |   |   |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1984</b> , 19____, to <b>1986</b> , that (I) (we) lost saw the deceased alive on <b>3/18</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |                            |  |
| 22b. SIGNATURE<br><b>W.H. Goldiner</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William H. Goldiner, MD</b>   |  | 22e. ADDRESS<br><b>St. Joseph Hospital Towson, Md.</b>  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/21/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem.</b>                     |                            |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>P. Davidson-Randall</b>                             |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. COUNTY</b>  |  |   |   |  |                            |  |

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CERTIFICATE # 07100



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-01457

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|--|--|---|--|---|--|---|--|---|--|--|---|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | REG. NO.   |   |  |
| 1- FOR STATE REGISTRAR   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  |   |  | 2b. HOUR   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HELEN REGINA ROBERTSON</b>  |  |   |  |   | <b>3 - 22 - 86</b>   |   |  |   |  | <b>4:05A M</b>   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 2, 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>72</b>                                 |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>               |  |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GMC-6701 N. CHARLES STREET</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Timonium</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2200 Dulany Valley Rd. 21093</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Horstschneider</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Horstschneider</b> |   |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>217-26-2509</b>  |  | 17. INFORMANT ADDRESS<br><b>Robert R. Robertson Same</b>  |  |   |  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY FAILURE AND RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ADENOCARCINOMA OF LEFT OVARY</b>  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 MONTHS</b><br><b>2 MONTHS</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/21/86</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ADENOCARCINOMA OF LEFT OVARY AND COLON</b>   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>86</b> , to <b>3/22</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/21</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE <b>L. RUBIN</b>   |  |   |  |   | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>3/22/86</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. RUBIN, M.D.</b>   |  |   |  |   | 22e. ADDRESS<br><b>GMC-6701 N. CHARLES ST.</b>                           |   |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>March 25, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Timonium, Baltimore Co., Md.</b>    |  |   |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Mitchell-Wiedefeld Home, Inc.</b>  |  |   |  |   | ADDRESS<br><b>6500 York Rd. Balto., Md. 21212</b>                        |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 0 7 1 0 2  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>DAWN   |  | MIDDLE  |  | LAST<br>ROBINS   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 10 '86 |  | 2b. HOUR<br>M                                   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 10 66   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>20 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                          |  | 7. IF UNDER 24 HRS<br>HOURS MIN.                |  |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>Usa  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY  |  |  |  |   |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N.CHARLES ST. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  | 13e. STREET ADDRESS / ZIP CODE<br>3665 Wabash Avenue 21215 |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Robins  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eunice Hardy  |  |   |  |   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Unkn  |  | 17. INFORMANT<br>ADDRESS<br>Eunice Robins 3665 Wabash Avenue  |  |   |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Resp. Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARDIAC FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RENAL FAILURE</u>  |  |  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>   |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>86</u> to <u>3/10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>M. Sipple</u>   |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>3/10/86</u>  |  |  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. SIPPLE, M.D.   |  | 22e. ADDRESS<br>GBMC-6701 N.CHARLES ST.  |  |   |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/15/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.  |  |  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H West  |  | ADDRESS<br>4300 Wabash Avenue  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 13 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

UNITED STATES

DEPARTMENT OF AGRICULTURE

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CHILMANN BRAND

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07103

1- FOR  
STATE  
REGISTRAR

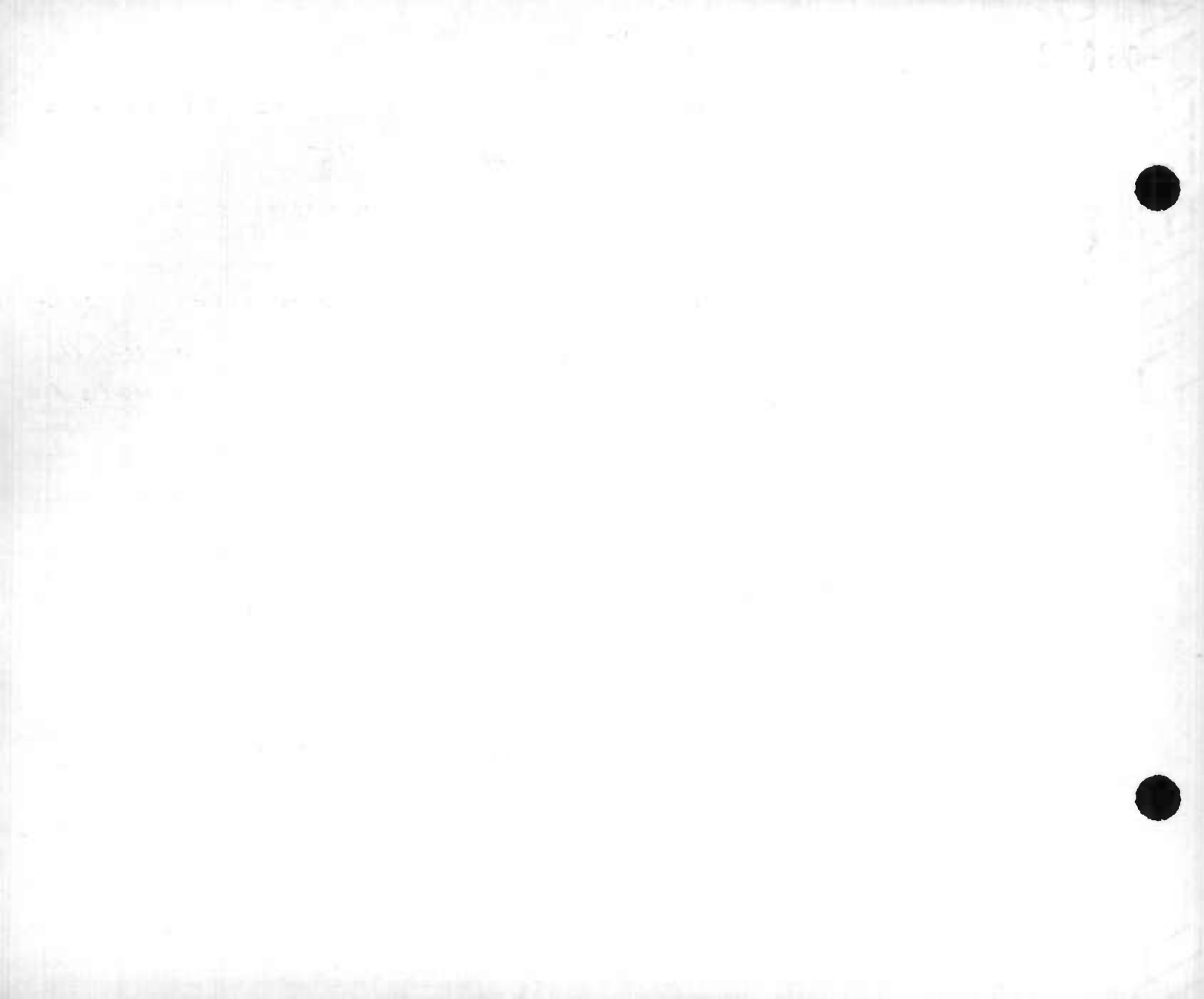
REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDWARD FRANK ROBINSON</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 19 86</b>  |  | 2b. HOUR<br><b>7<sup>30</sup> A.M.</b>                               |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 07 11</b>   |   | 6. AGE [IN YEARS (LAST BIRTHDAY)]<br><b>75</b> YRS.                                  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>00 00</b>                       |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI OF BALTIMORE</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Pennsylvania Railroad</b> |
| 13a. STATE<br><b>MD</b>   |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br><b>1128 MYRTLE AVE - 21201</b>     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK ROBINSON</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DORA JOHNSON</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 220-07-5239</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>ERNESTINE H. ROBINSON 1128 MYRTLE AVE</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumococcal Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Locally recurrent lung carcinoma</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>03/19</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>lung carcinoma</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>03/18</b> 19 <b>86</b> , to <b>03/19</b> 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>03/19</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>K. Salzman</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>03/19/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KARL SALZMAN</b>  |  | 22e. ADDRESS<br><b>SINAI OF BALTIMORE</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>3/24/86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Vet.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Md.</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H, West</b>   |  |   | ADDRESS<br><b>4300 Wabash Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1986</b>                  |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





00-00784

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 7 1 0 4

|   |  |   |   |   |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gertrude M. Robinson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 14 86</b> |   |  | 2b. HOUR<br><b>2:05a M</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 8 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Summit Nursing Home</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Balto., Md.<br/>4410 Pen Lucy Rd. #21229</b>    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>D. Harrel</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth ?</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>213-74-4727</b>  |  | 17. INFORMANT<br><b>4410 Pen Lucy Rd. - Balto., Md.<br/>Neva I. Soukup #21229</b>   |   |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Probable Renal Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>1. Severe anemia 2. Arteriosclerotic Cardiovascular Disease</b>  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 14, 1986</b> to <b>March 14, 1986</b> , that (I) (we) last saw the deceased alive on <b>March 13, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James E. Rowe</b> M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |   |  | 22c. DATE SIGNED<br><b>3-14-86</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James E. Rowe, M. D.</b>  |  |   |   |   |  | 22e. ADDRESS<br><b>413 Commonwealth Avenue<br/>Baltimore, Maryland 21228</b>         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-17-86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Landon Park Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Truman Schwartz</b>   |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1986</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_



00-01637

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 7 1 0 5

|  |   |   |  |  |                                    |  |  |  |
|--|---|---|--|--|------------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH  |  |                                    | 2b. HOUR   |  |  |
| FIRST MIDDLE LAST<br>MARTHA C. ROBINSON  |   |   | MONTH DAY YEAR<br>3 22 86  |  |                                    | 11:30AM  |  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |                                    | 7. IF UNDER 1 YEAR   |  |  |
| FEMALE   | WHITE   | MONTH DAY YEAR<br>11 25 08  | 77 YRS.  |  |                                    | MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |                                    |  |  |  |
| Virginia   | U.S.A.  |   | Baltimore County MD.   |  |                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY          |  |
| Catonsville  | 617 Hiltop Road   |   |  | Line Worker  |                                    |  | Crown, Cork & Seal                         |  |
| 13a. STATE   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN  |                                    | 13d. STREET ADDRESS / ZIP CODE   |  |  |
| Maryland   |   |   | Baltimore  | Catonsville  |                                    | 617 Hiltop Road 21228  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |  |                                    |  |  |  |
| Samuel J. Corbin   |   |   | Ida Barkley  |  |                                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |   | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT ADDRESS  |  |  |
| NO   |   |   | 227-03-2940  |  |                                    | James L. Corbin 617 Hiltop Road 21228  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sudden cardiac death<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary artery atherosclerosis Years<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br>Chronic atrial fibrillation, congestive heart failure, S/P 1981 cerebral infarction |   |   |  |  |                                    |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| 19a. DATE OF OPERATION   |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   |   |  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 15, 1982, to March 22, 1986, that (I) (we) last saw the deceased alive on Feb. 19, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |                                    |  |  |  |
| 22b. SIGNATURE<br>Bruce R. McCurdy MD  |   |   | DEGREE   |  |                                    | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   | 22e. ADDRESS   |  |                                    | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |
| Bruce R. McCurdy   |   |   | 1311 Francis Avenue  |  |                                    | 3/24/86  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial   |   |   | 3/25/86  |  | Loudon Park Cemetery               |  | Baltimore Maryland                         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |   |   | 25a. DATE REC'D. BY REGISTRAR  |  |                                    | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229   |   |   | MAR 27 1986  |  |                                    | John Davidson-Randall  |  |  |

MEDICAL CERTIFICATION

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]*

00-02017

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 0 7 1 0 6  
CERTIFICATE OF DEATH

|  |   |   |  |
|--|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |   | REG. NO.  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH MONTH DAY YEAR  |  |
| Ollie Jane ROCCISANO   |   | March 28 1986   |  |
| 3 SEX  | 4 RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |
| Female   | White   | July 21 1906  | 79   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |
| Va.  | USA   |   | Baltimore County MD.   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(IF NOT WORKING FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Rossville  | Franklin Square Hospital  | Housewife   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE                                 |
| 13a. STATE   | 13b. COUNTY   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 1905 Old Turkey Pt. Rd. 21221                                  |
| Md.  | Balto.  |   |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME  |   |  |
| FIRST MIDDLE LAST  | FIRST MIDDLE LAST   |   |  |
| unknown  | unknown   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   | 17. INFORMANT ADDRESS   |  |
| no   | 578-24-0601   | Donna Davis 1905 Old Turkey Pt. Rd. 21221   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> <u>Dehydration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Liver Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Gastrointestinal Bleed</u>   |   |   |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
|  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
|  |   |   |  |
| 22a. I certify that (this hospital) attended the deceased from <u>March 24</u> 19 <u>86</u> , to <u>March 28</u> 19 <u>86</u> that (we) last saw the deceased alive on <u>March 28</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.                                       |   |   |  |
| 22b. SIGNATURE   | DEGREE  | 22c. DATE SIGNED  |  |
| <i>Vincent Morgan</i>  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS  |   |  |
| Vincent Morgan   | 9000 Franklin Square Drive  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |
| Burial   | 4/1/86  | Oak Lawn Cemetery   | Baltimore Maryland   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   | 25a. DATE REC'D. BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE  |  |
| Connelly Funeral Home 300 Mace Ave. 21221  | APR 01 1986   | <i>Julia Davidson-Randall</i>   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

51050-00



00-01366

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Jesse T. ROGERS   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 21, 1986                       |  | 2b. HOUR<br>2:25P M  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 16 1903   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.                                  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel                                     |  |
| 13a. STATE<br>Maryland   |   |   | 13b. CITY OR TOWN<br>Baltimore  | 13c. CITY OR TOWN<br>Dundalk   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Cyrus Rogers   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Harriet Arrington          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.<br>213-07-9972   | 17. INFORMANT<br>707 Old North Point Rd 21224<br>Mrs. Mary Jean Perzynski   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Carcinoma of the penis and azotemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c)   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 5, 1986, to March 21, 1986, that (I) (we) lost the deceased alive on March 21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>J. Schwartzman   |   | DEGREE  |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Schwartzman, M.D.  |   | 22e. ADDRESS<br>9000 Franklin Square Drive-21237  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>3/24/86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Funeral Home 7922 Wise Ave.  |   | Baltimore, MD 21222   |   | 25. DATE REC'D. BY REGISTRAR<br>MAR 26 1986  |  |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP





00-01621

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |   |   |   |  | 8   | 6 | 0                              | 7  | 1                                    | 0 | 8 |
|---|--|--|--|--|---|---|---|---|--|---|---|--------------------------------|--|--------------------------------------|---|---|
| 1- FOR STATE REGISTRAR  |  |  |  |  |   |   |   |   |  | REG. NO.  |   |                                |  |                                      |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HYMAN ROSENBAUM</b>  |  |  |  |  |   |   |   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-23-86</b>                               |   |                                |  | 2b. HOUR<br><b>12<sup>41</sup>AM</b> |   |   |
| 3. SEX<br><b>M ALE</b>  |  |  | 4. RACE<br><b>W HITE</b>   |  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11-16-11</b>   |   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS<br>HOURS MIN.        |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CZECHOSLOVAKIA</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |   |   |                                |  |                                      |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO COUNTY GENERAL HOSPITAL</b> |  |   |   |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAINTENANCE</b> |   |                                | 12b. KIND OF BUSINESS OR OCCUPATION<br><b>TRAFFIC &amp; TRANSIT CITY OF BALTO.</b> |                                      |   |   |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>RANDALLSTOWN</b>                              |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>4914 OLD COURT RD. 21133</b>  |   |   |                                |  |                                      |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALEX ROSENBAUM</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BETTY UNKNOWN</b> |   |   |   |  |   |   |                                |  |                                      |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>579-12-0238</b>   |  |   | 17. INFORMANT ADDRESS<br><b>MRS. IDA ROSENBAUM 4914 OLD COURT RD. 21133</b>   |   |   |  |   |   |                                |  |                                      |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |                                |  |                                      |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |   |   |   |   |  |   |   |                                |  |                                      |   |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |                                |  |                                      |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |   |                                |  |                                      |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |   |                                |  |                                      |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-07-86</b> to <b>3-23-86</b> , that (I) (we) lost saw the deceased alive on <b>3-23-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |   |   |   |  |   |   |                                |  |                                      |   |   |
| 22b. SIGNATURE<br><b>R. DEPESTRE</b>  |  |  |  |  |   | DEGREE<br><b>M.D.</b>   |   |   |  | 22c. DATE SIGNED<br><b>3-23-86</b>  |   |                                |  |                                      |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. DEPESTRE</b>   |  |  |  |  |   | 22e. ADDRESS<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b>  |   |   |  |   |   |                                |  |                                      |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>3/24/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>AITZ CHAIM CEM</b>           |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |  |   |   |                                |  |                                      |   |   |
| 24. FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b>  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>   |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>G. Davidson-Henderson</b>                          |   |                                |  |                                      |   |   |
| 6010 REISTERSOTWN RD. BALTO, MD 21215   |  |  |  |  |   |   |   |   |  |   |   |                                |  |                                      |   |   |

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

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END

NOT TO BE

00-01453

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |   |  |                                    |  |                                |  |
|---|--|---|--|--|--|---|--|------------------------------------|--|--------------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR |  | 2b HOUR                        |  |
| Grace Louise Rosier   |  |   |  |  |  |   |  | March 21, 1986                     |  | M                              |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6 AGE<br>(IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS     |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| F   |  | W   |  | Mar. 29, 1903  |  | 82 YRS  |  |                                    |  |                                |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |                                    |  | MD.                            |  |
| Md.   |  | USA   |  |  |  | Baltimore Co.,  |  |                                    |  |                                |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |                                    |  |                                |  |
| Towson  |  | Presbyterian Home of Maryland   |  | Sales  |  | Dept. Store   |  |                                    |  |                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |   |  |                                    |  |                                |  |
| 13a STATE   |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e STREET ADDRESS / ZIP CODE      |  |                                |  |
| Md.   |  | Baltimore   |  | Towson   |  |   |  | 1306 Aintree Rd.                   |  | 21204                          |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |                                    |  |                                |  |
| Charles Weibe   |  |   |  | Alice McCabe   |  |   |  |                                    |  |                                |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT   |  | ADDRESS   |  |                                    |  |                                |  |
| No  |  | 215 03 2145   |  | Mr. Lester Stagge  |  | 1306 Aintree Road   |  | -04                                |  |                                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Mid</u><br><u>1 Day</u><br><u>4 yr</u> |  |   |  |  |  |   |  |                                    |  |                                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |   |  |  |  |   |  |                                    |  |                                |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                    |  |                                |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |                                    |  |                                |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                    |  |                                |  |
| 22 I certify that (I) (the hospital) attended the deceased from <u>NOV 85</u> to <u>MAR 21 86</u> , that (I) (we) last saw the deceased alive on <u>MAR 20 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |   |  |  |  |   |  |                                    |  |                                |  |
| 22b SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c DATE SIGNED   |  |                                    |  |                                |  |
| <u>S. J. VENABLE JR MD</u>  |  |   |  |  |  | <u>3-21-86</u>  |  |                                    |  |                                |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e ADDRESS   |  |  |  |   |  |                                    |  |                                |  |
| S. J. VENABLE JR MD   |  | 7215 YORK RD - BALTIMORE MD   |  |  |  |   |  |                                    |  |                                |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE   |  |                                    |  |                                |  |
| Burial  |  | 3/24/86   |  | Moreland Mem. Park   |  | Baltimore, Md.  |  |                                    |  |                                |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a DATE REC'D. BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE   |  |                                    |  |                                |  |
| MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.   |  |   |  | MAR 26 1986  |  | <u>[Signature]</u>  |  |                                    |  |                                |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their glass case should be moved to the funeral home before the funeral. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show only injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF JUSTICE

IN RE

JOHN EDGAR HOOVER

JOHN EDGAR HOOVER, Defendant.

JOHN EDGAR HOOVER, Defendant.

JOHN EDGAR HOOVER, Defendant.

JOHN EDGAR HOOVER, Defendant.



JOHN EDGAR HOOVER, Defendant.

JOHN EDGAR HOOVER, Defendant.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 1 0

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |  |  |   |  |
|---|--|---|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Andrew E. Rossi</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 01 86</b>              |  |   | 2b. HOUR<br><b>8:55 PM</b>   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 29 08</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS HRS. MIN.<br><b>77</b>           |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina - USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SELF EMP.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2600 CREIGHTON AVE. 21234</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GOTTARDO Rossi</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EMMA MARINO</b> |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>213091082</b>  |   | 17 INFORMANT<br><b>FAMILY RECORDS</b>  |   |  | ADDRESS  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>due to ACUTE MYOCARDIAL</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(c) <b>INFARCTION.</b> |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0  |  |   |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3-1-86</b> to <b>3-1-86</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-1-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death <b>86</b>                     |  |   |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Dr. Chuladi</b>  |  |   |   | DEGREE<br><b>MD</b>  |   |  |  | 22c. DATE SIGNED<br><b>3-2-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. GHILADI, MD</b>   |  |   |   | 22e. ADDRESS<br><b>7600 OSLER Dr. Towson 21204</b>   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>3-5-1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO MARYLAND</b>         |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPEL OF MEMORIES HARFORD</b>   |  |   |   | ADDRESS<br><b>8800 ROAD</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1986</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



0-00588

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 7 1 1 1

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RALPH</b><br><b>RALPH</b>   |  | MIDDLE  |  | LAST <b>RUOFF</b><br><b>RUOFF</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAR. 17, 1986</b>                                     |  | 2b. HOUR<br><b>11 A.M.</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 20 1910</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PUNCH PRESS OPERATOR</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ROEPER CORP.</b>   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3338 KENYON AVE. 21213</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES J. RUOFF</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIE SCHORR</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>NO <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br><b>217-12-3902</b>  |  | 17. INFORMANT ADDRESS<br><b>Loretta Montalbano (dghtr) P.O. Box 72 Owings Mills Md</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Progressive Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>End stage COPD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)     |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Cardiac arrest</b>  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-14</b> , 19 <b>86</b> , to <b>3-17</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3-17</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>3/18/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GRAVE &amp; PATTERSON</b>  |  |   |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/19/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1986</b>  |  |
| 24. FUNERAL HOME<br>NAME ADDRESS<br><b>SCHMIDT FUNERAL HOME, INC.<br/>3331 Brehms Lane, Balto. Md. 21213</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2, and hold them until the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

204 COTTON 21866

CWCA

WINTER





00-02116

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

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REG. NO.

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Annie Laura Sawyer   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 30, 1986 |   |  | 2b. HOUR<br>10:45 <sup>AM</sup>   |  |   |  |
| 3. SEX<br>F   |  | 4. RACE<br>W   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 8, 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89 YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co., MD                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Presbyterian Home of Maryland |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.   |  |  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George P. Ashburn   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mildred Booth  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216 09 8292A  |   | 17. INFORMANT<br>ADDRESS<br>Presbyterian Home of Md. Towson, Md. 21204  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebrovascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MIN<br>HRS.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>ASCVD</u>  |  |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u> 40   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>4-1-86  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. J. VENABLE  |  |  |   | 22e. ADDRESS<br>7215 YORK RD  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>4/2/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Baltimore, Md.            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME, INC.   |  |  |   | ADDRESS<br>6500 York Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 01 1986                                  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages one and two should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

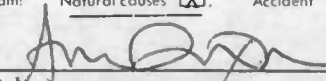

REG. NO.

1- FOR  
STATE  
REGISTRAR

4/9/86 rja

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|  |                         |  |  |   |   |  |   |  |
|--|-------------------------|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PATRICIA Aileen SAYLOR</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>3-23-86 19</b> |   |   | 2b. HOUR<br><b>11:29 pm</b>  |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 27, 1946 40 YRS.</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>40</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br><b>3-23-86 19</b>                                     | 2d. HOUR<br><b>11:29 pm</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Francis Reilly</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Doris E. Agnor</b>   |  | 13e. STREET ADDRESS<br><b>7724 Oakleigh Road 21234</b>  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-44-8296</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>George M. Saylor same as 13e</b>   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic hypertensive cardiovascular</b><br><del>XXXXXXXXXXXXXXXXXXXX</del><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                         |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |                         |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)     |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br>  |                         |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |   |   |  | DATE SIGNED <b>3-24-86</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                         |  | ADDRESS<br><b>111 PennStreet</b>   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         |  | 23b. DATE<br><b>3/27/1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Cem.</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Balto., MD</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |                         |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>                               |  | 25b. REGISTRAR'S SIGNATURE<br> |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY WAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07114  
REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>RICHARD S SCHALL Jr</b>  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>Mar. 3, 1986</b>   |  | 2b HOUR<br>M<br><b></b>  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 12 1898</b>                             |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |  | MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Manor Care Ruxton</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret Mgr.</b> |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>Leather</b>  |  | 13a STATE<br><b>Md</b>  |  | 13b COUNTY<br><b>Balto</b>   |  |
| 13c CITY OR TOWN<br><b>Towson</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>928 Southerly Rd. 21204</b>                    |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard S Schall</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Augusta Lawrence</b>   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO.<br><b>212 07 2134A</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Russell Niller 1109 Echo Ct. North 21204</b>    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Cancer of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u><br><u>6 weeks</u> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>2-17-86</u> to <u>3-2-86</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/2/86</u> 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b SIGNATURE<br><u>Leslie E. Leslie</u>  |  | DEGREE<br><b>Dr.</b>  |  | 22c DATE SIGNED  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Leslie</b>   |  | 22e ADDRESS<br><b>3501 St. Paul St.</b>   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>3-5-86</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn</b>                                |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Baltimore Md.</b>   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAK 11 1986</b>  |  |  |  |
| 25b REGISTRAR'S SIGNATURE<br><u>Wardell</u>   |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
|---|---------|------------------------------|--|--|--|---|--|---|--|--------------------------|--|---|--|----------|--|----------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST                        |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH   |  |                          |  | 2b. HOUR  |  |          |  |                            |  |  |  |
| Alma  |         | V.                           |  | Schmidt  |  | DATE MATED <input checked="" type="checkbox"/> 3 20 19 86 |  |   |  | 3 24 19 86               |  |   |  |          |  |                            |  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             |  | 6. AGE (IN YEARS)  |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD |  |   |  | 2d. HOUR |  |                            |  |  |  |
| Female  | White   | 2-18-1907                    |  | 79 YRS.  |  | MONTHS  |  | DAYS  |  | 3 24 19 86               |  |   |  | 8 30     |  |                            |  |  |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                      |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| Maryland  |         | USA                          |  | Baltimore County MD.   |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |                            |  |  |  |
| Owings Mills  |         |                              |  | 130 E. Harry Lane  |  |   |  | Homemaker   |  |                          |  | --  |  |          |  |                            |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| 13a. STATE  |         |                              |  | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN   |  |                          |  | 13d. INSIDE CITY LIMITS?  |  |          |  | 13e. STREET ADDRESS        |  |  |  |
| Maryland  |         |                              |  | Baltimore  |  |   |  | Owings Mills  |  |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  | 130 Harry Lane Apt E 21117 |  |  |  |
| 14. FATHER'S NAME   |         |                              |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |                          |  |   |  |          |  |                            |  |  |  |
| FIRST MIDDLE LAST   |         |                              |  |  |  |   |  | FIRST MIDDLE LAST   |  |                          |  |   |  |          |  |                            |  |  |  |
| John W. Spranklin Sr.   |         |                              |  |  |  |   |  | unknown   |  |                          |  |   |  |          |  |                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         |                              |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT   |  |                          |  | ADDRESS   |  |          |  |                            |  |  |  |
| no  |         |                              |  | 216-46-2914  |  |   |  | Annapolis MD 21403  |  |                          |  | Dr. John W. Spranklin Jr. 793C Fairview Ave                         |  |          |  |                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| PART I DEATH WAS CAUSED BY:   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| IMMEDIATE CAUSE (a) <u>ASCVD</u>  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| (b) <u>---</u>  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| (c) <u>---</u>  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| 19a. DATE OF OPERATION  |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                          |  | 20. AUTOPSY?  |  |          |  |                            |  |  |  |
|   |         |                              |  |  |  |   |  |   |  |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |  |                            |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                          |  |   |  |          |  |                            |  |  |  |
|   |         |                              |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
|   |         |                              |  | P.M. 19  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |         |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION   |  |                          |  |   |  |          |  |                            |  |  |  |
|   |         |                              |  |  |  |   |  | STREET CITY OR TOWN COUNTY STATE  |  |                          |  |   |  |          |  |                            |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| ACTUAL SIGNATURE  |         |                              |  | TITLE (SPECIFY)  |  |   |  | M.D.  |  |                          |  | MEDICAL EXAMINER  |  |          |  | DATE SIGNED                |  |  |  |
| <i>Stanley Z. Felsenberg</i>  |         |                              |  | M.D. <i>Dep 074</i>  |  |   |  |   |  |                          |  |   |  |          |  | 3/20/86                    |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |                              |  | ADDRESS  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| Stanley Z. Felsenberg MD  |         |                              |  | 11 E. Chesebrough  |  |   |  | 31202   |  |                          |  |   |  |          |  |                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |                              |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                          |  | 23d. LOCATION   |  |          |  |                            |  |  |  |
| Burial  |         |                              |  | 3-28-86  |  |   |  | Baltimore National Cem  |  |                          |  | Baltimore City MD   |  |          |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| NAME ADDRESS  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| Loring Byers Funeral Directors, Inc   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| 8728 Liberty Rd. Randallstown, MD 21133   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| MAR 27 1986   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| 25b. REGISTRAR'S SIGNATURE  |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |
| <i>Julia Davidson-Randall</i>   |         |                              |  |  |  |   |  |   |  |                          |  |   |  |          |  |                            |  |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25MBP  
DHMH 17  
(VR A15 ME (5))

Handwritten notes and markings on the right margin, including a large 'X' and other illegible scribbles.

Faint, mostly illegible text covering the main body of the page, possibly representing a document or report.



00-01245

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07116

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                            |   |  |  |  |   |  |
|---|--|--|---|--|----------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CAROLINE M. SCHMITT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 22 86</b> |  | 2b. HOUR<br><b>6:20P M</b> |   |  |  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 14 1897</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>88</b>                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                    |  |  |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Summitt Nursing Home</b> |   |  |                            | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Civil Service</b> |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Federal Government</b>  |  |   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br><b>Maryland</b>  |  |  |   | 16b. COUNTY<br><b>Baltimore</b>  |                            | 16c. CITY OR TOWN<br><b>Baltimore</b>   |  | 17. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |   |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Rudolf Schmitt</b>   |  |  |   | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caroline Persch</b>  |                            |   |  | 20. STREET ADDRESS / ZIP CODE<br><b>4406 Old Frederick Rd. 21229</b>   |  |   |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 22. SOCIAL SECURITY NO.<br><b>WW II</b>  |   | 23. INFORMANT<br><b>Shelton B. Bosley</b>  |                            | 24. ADDRESS<br><b>1318 Gatefield Rd. 21228</b>  |  | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 26. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Upper Respiratory Infection</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST |  |  |   |  |                            |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |   |  |                            |   |  |  |  |   |  |
| 27a. DATE OF OPERATION  |  | 27b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |                            | 28a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |  | 28b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 29b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                            |   |  |  |  |   |  |
| 30a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 30b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 30c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                            |   |  |  |  |   |  |
| 31. I certify that (I) (this hospital) attended the deceased from <u>May 7, 1980</u> to <u>March 22, 1986</u> , that (I) (we) lost saw the deceased alive on <u>March 22, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |   |  |                            |   |  |  |  |   |  |
| 32a. SIGNATURE<br><b>James E. Rowe</b>  |  |  |   | 32b. DEGREE<br><b>MD</b>   |                            |   |  | 32c. DATE SIGNED<br><b>March 24, 86</b>  |  |   |  |
| 33a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Rowe</b>  |  |  |   | 33b. ADDRESS<br><b>413 Commonwealth Avenue</b>   |                            |   |  |  |  |   |  |
| 34a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 34b. DATE<br><b>3/26/86</b>  |   | 34c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>  |                            | 34d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                 |  | 35. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1986</b>   |  |   |  |
| 36. FUNERAL DIRECTOR<br>NAME<br><b>Hulbard Funeral Home, Inc.</b>   |  |  |   | 36b. ADDRESS<br><b>4107 Wilkens Ave. 21229</b>   |                            |   |  | 37. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed in the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the original physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 1 7

REG. NO.

|  |  |  |  |   |                       |   |  |
|--|--|--|--|---|-----------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Cora M. Schneider  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 5, 1986 |   | 2b. HOUR<br>8:00 A.M. |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 15, 1888  |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>97<br>YEARS MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Pikesville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Pikesville Nursing & Convalescent |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mill Worker   |                       | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br>Maryland Baltimore   |  |  |  | 13b. CITY OR TOWN<br>Baltimore  |                       | 13c. STREET ADDRESS / ZIP CODE<br>5616 Mattfeldt Avenue 21209   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jacob Schneider  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Jane Michael  |                       |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>No   |  | 16b. SOCIAL SECURITY NO.<br>213 05 0412  |  | 17. INFORMANT<br>ADDRESS<br>Anna R. Daily 903 Cooks Lane 21229  |                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD, HCV, P/S</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>P/S post-op gastric</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>gastric</u> |  |  |  |   |                       |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>&gt; 10 yr</u> |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |                       |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                       |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> 19 <u>76</u> to <u>11/12</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                       |   |  |
| 22b. SIGNATURE<br><u>Dr. Myung Hee Chung</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                       | 22c. DATE SIGNED<br><u>3/5/86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Myung Hee Chung   |  |  |  | 22e. ADDRESS<br>5670B The Alameda, Baltimore, Md. 21239   |                       |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>03/07/1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Balto. Co., Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Burgeon-Henss Funeral Home, Balto., Md. 21211  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 6 1986   |                       | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>  |  |

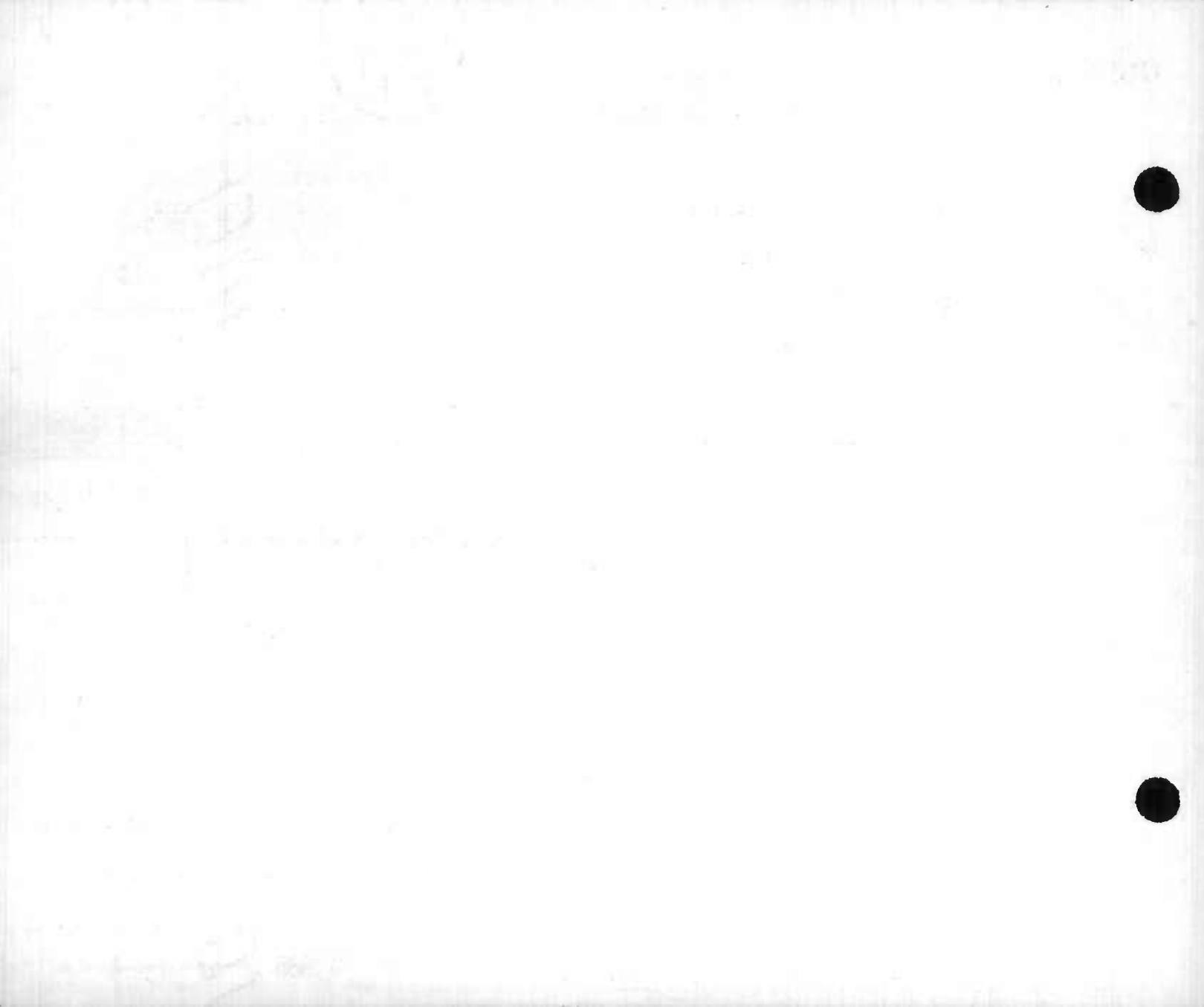
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



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 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 6 0 7 1 1 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                            |  |  |
|---|--|--|--|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Henry Schroeder</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 6 86</i> |   | 2b. HOUR<br><i>6 30 AM</i> |  |  |
| 3. SEX<br><i>male</i>   |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 6 1891</i>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>95</i> YRS<br>IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS: MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Chapel Hill Conv. Home</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>md.</i>  |  |  |  | 13b. COUNTY<br><i>Randallstown</i>  |                            | 13c. CITY OR TOWN  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Ernest Schroeder</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Julia Wernecke</i>  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>217-01-5659</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Donald F. Schroeder Randallstown, Md.</i>  |                            |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute ASCE II</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 hrs</i><br><i>20 hrs</i><br><i>30 hrs</i>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Atherosclerosis</i>   |  |  |  |   |                            |  |  |
| 19a. DATE OF OPERATION<br><i>none</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>none</i>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <i>86</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/21</i> , 19 <i>81</i> , to <i>3/6</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3/6</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |  |  |  |   |                            |  |  |
| 22b. SIGNATURE<br><i>Martin Feldman</i>   |  |  |  | DEGREE<br><i>MD</i>   |                            | 22c. DATE SIGNED<br><i>3/6/86</i>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Martin Feldman</i>  |  |  |  | 22f. ADDRESS<br><i>1 E. Cherry Hill Rd Rens. MD 21136</i>   |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3/8/86</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park</i>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Woodlawn Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Cline Funeral Home</i>   |  |  |  | 25. DATE FILED BY REGISTRAR<br>MAR 1 1986   |                            |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 for the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Their please return original and duplicate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other trauma present, the medical examiner must be notified at once.

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(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |   |  |
|--|--|---|--|--|---|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |  |   |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John Bernard Schroeder</b>  |  |   |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>1986</b>                |   |  | 2b. HOUR<br><b>11 A.M.</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>28</b> YEAR <b>16</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                      |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>116 Hedgewood Rd.</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 13c. STREET ADDRESS<br><b>116 Hedgewood Rd. 21093</b>                                 |  |   |  |
| 14 FATHER'S NAME<br>FIRST <b>John H.</b> MIDDLE <b>Schroeder</b> LAST <b></b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ella</b> MIDDLE <b>F.</b> LAST <b>Thomas</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-09-3635</b>   |  | 17 INFORMANT<br>ADDRESS <b>Same as #13</b><br><b>Mrs. Lorraine Schroeder</b>   |   |   |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SCV.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>20 years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus; previous C.V.A.</b>   |  |   |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>1925</b> to <b>3/11/86</b> , that (1) (we) lost saw the deceased alive on <b>3/7/86</b> , 19 <b></b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                  |  |   |  |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Paul J. Edgar</b>   |  |   |  | DEGREE<br><b>MD.</b>   |   |   |  | 22c. DATE SIGNED<br><b>3/11/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Paul J. Edgar MD.</b>  |  |   |  | 22e. ADDRESS<br><b>660 Krimlwork Dr., Towson, Md.</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>3/11/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |   |  | ADDRESS<br><b>Balto., Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. K. Kunkin-Rodella</b>   |  |

11



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07120

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUTH</b>  |  | FIRST <b>W.</b>   |  | MIDDLE <b>SCHULTZ</b>   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>6</b> YEAR <b>86</b>  |  | 2b. TIME OF DEATH<br><b>4:35 P.M.</b>             |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>8</b> YEAR <b>04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | 7. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3628 FORDS LA., APT. B #21215</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>ISAAC</b> MIDDLE <b>SILVER</b> LAST <b>SILVER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>SARAH</b> MIDDLE <b>JOFFE</b> LAST <b>JOFFE</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-46-0034</b>  |  | 17. INFORMANT<br><b>MRS. EDITH S. BORDEN</b>  |  | 17a. ADDRESS<br><b>APT. 33</b>  |  | 17b. CITY<br><b>BALTO., MD</b>   |  | 17c. ZIP CODE<br><b>21210</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute Pulm Oedema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Infarction</b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Dehydration</b>  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____ that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Hafeez A Syed</b>   |  |   |  | DEGREE  |  |   |  | 22b. DATE SIGNED<br><b>3/6/86</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAFAEEZ A SYED M.D.</b>  |  |   |  | 22d. ADDRESS<br><b>BALTIMORE COUNTY GEN. HOSPITAL</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>MAR. 9, 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW FRIENDSHIP</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. They please remove carbon copies. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked item 18 shows any injury, or other traumatic event, the medical examiner will be notified immediately.

1915

RECEIVED

1915



00-02008

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

86 07121

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Justus Schweitzer</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 28, 1986</b> |   |  | 2b. HOUR<br>M<br><b>M</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 2, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1915 Turkey Point Rd.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FORMOST OF WORKING LIFE)<br><b>Counselor</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Social Services</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Essex</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1915 Turkey Point Rd. 21221</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Conrad Schweitzer</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Mae Taeuber</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 03 3124</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ann L. Schweitzer, Wife</b>  |  |   |  | Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPIRATION</b>  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hour</b>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>PARKINSON'S DISEASE, SEVERE</b>  |  |   |  |   |  |   |  | <b>10 min</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>  |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>3/26</b> , 19 <b>86</b> , to <b>MARCH 28, 19 86</b> , that (b) (we) lost sight of the deceased before on <b>APR 8, 19 86</b> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (If a witness did not view the body after death, so state.) |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles Hoesch</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>3/2/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES HOESCH</b>   |  |   |  | 22e. ADDRESS<br><b>9712 BELMONT RD. BAYTON, MD 21236</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  | 23b. DATE<br><b>4/1/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home PA 1407 Old Eastern Ave</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia...</b>   |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

APR 22, 1968

COMMITTEE

MEMORANDUM

TO : DIRECTOR

FROM : [illegible]

SUBJECT : [illegible]

DATE : [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

28. [illegible]

066039

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 7 1 2 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |   |  |  |
|---|--|---|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James f Seal   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3/4/86                          |   |  | 2b. HOUR<br>4:19A M  |  |   |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 1 15  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE) OR FOREIGN COUNTRY<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED TRUCK DRIVER   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   | 13b. COUNTY<br>CARROLL   |   |  | 13c. CITY OR TOWN<br>MANCHESTER  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FREDERICK G. SEAL   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BLANCHE BURTON        |   |  | 16. STREET ADDRESS / ZIP CODE<br>4701 WARNER DR. 21102   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-03-0941 |   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. CATHERINE L. SEAL 4701 WARNER DR. 21102   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronal vascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease, stroke</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, INDICATE MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22. I certify that (1) this hospital attended the deceased from <u>2/17/86</u> to <u>3/4</u> 19 <u>86</u> , that (1) we last saw the deceased on <u>3/3/86</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above (1) we (1) did (1) did not view the body after death.  |  |   |  |   |  |  |  |   |  |  |
| 22a. SIGNATURE<br><u>Ernest N. Hackett</u>  |  |   | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/4/86  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ERNEST N. HACKETT  |  |   | 22d. ADDRESS<br>9701 FRANKLIN SQUARE BALTIMORE 21227                   |   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |   | 23b. DATE<br>3/6/86  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MEADOWRIDGE MEMORIAL   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>HOWARD MD                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ELINE FUNERAL HOME, REISTERSTOWN, MD.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1986  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |

RETIRED TRUCK DRIVER

4701 WARNER DR. 51102

HANCHEDSTER

CARROLL

LARYLAND

BURTON

BLANCHE

SEAL

G.

FREDERICK

4701 WARNER DR. 51102

514-05-0941 MRS. CATHERINE L. SEAL

NO

10

OWARD

MEADOWRIDGE MEMORIAL

5/6/86

BURIAL

ELINE FUNERAL HOME, REISTERSTOWN, MD.

00-00495

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Herbert Selenkow   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 11 86                         |   |  | 2b. HOUR<br>3:30 AM  |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 3 19  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS                                      |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>OWINGS MILLS  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2B NOBILITY COURT 21117 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SALES REP. |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETAIL  |  |
| 13a. STATE<br>MARYLAND   |  |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>OWINGS MILLS  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ABRAHAM SELENKOW   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ROSE JAFFEE  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  |  |  | 16b. SOCIAL SECURITY NO.<br>WW II 215-16-7636   |  | 17. INFORMANT<br>ADDRESS<br>IDA ROSS 34 EWING DR. - REISTERSTOWN, MD 21136     |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Renal Insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Vascular Insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) NASCUD<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br>Ulcer of leg.  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/9, 19 77, to 3/11, 19 86, that (I) (we) last saw the deceased alive on 2/19, 19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.    |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>J. M. McLean M.D.<br>DEGREE  |  |  |  |   |  | 22c. DATE SIGNED<br>3/11/86  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HEBREW MEMORIAL F.H. INC.   |  |
| 22e. ADDRESS<br>21208 REISTERSTOWN RD  |  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>3-13-86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>BALTIMORE HEBREW |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>REISTERSTOWN BALTO MD |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HEBREW MEMORIAL F.H. INC.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 17 1986                                   |   | 25b. REGISTRAR'S SIGNATURE<br>S. L. Friedman   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by you, it is to be filed directly with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death. Page 3 should be detached for use on the burial transit permit. This permit removes carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

BP





00-00589

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 8 0 7 1 2 4

REG. NO.

|  |  |  |   |   |                              |  |  |
|--|--|--|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANK H. SEVICK</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 14 86</b> |   | 2b. HOUR<br><b>8:40 P.M.</b> |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 19 07</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON, MD.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | 13e. STREET ADDRESS / ZIP CODE<br><b>3103 Hiss Ave. 21234</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Sevick</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Barbara Stolba</b>  |                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-24-3340</b>   |   | 17. INFORMANT ADDRESS<br><b>Rhea Sevick (wife) same address</b>   |                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe Congestive &amp; ischemic</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Heart disease.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |                              |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-15</b> 19 <b>86</b> , to <b>3-14</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3-14</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |  |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>A.H. Ghiladi</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                              | 22c. DATE SIGNED<br><b>3-17-86.</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.H. GHILADI, MD.</b>  |  |  |   | 22e. ADDRESS<br><b>7600 OSLER Dr. Towson 21204</b>  |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/18/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bohemian Nat'l</b>   |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schilmunek Funeral Home, Inc.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 18 1986</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| 25c. ADDRESS<br><b>9705 Belair Rd., Balto. Md. 21236</b>   |  |  |   |   |                              |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

*[Faint, illegible handwritten text covering the page]*



0-00673

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 2 5

REG. NO.

FOR  
STATE  
REGISTRAR

|   |   |   |  |  |                                   |
|---|---|---|--|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Maxine L. Seward   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>03 - 18 - 1986   |  | 2b. HOUR<br>5:30 P.M.  |                                   |
| 3. SEX<br>Female  | 4. RACE<br>white  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05 - 13 - 1929  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS  |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CRESTON N.C.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE Co. MD.                            |                                   |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CO. GEN. HOSPT. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LYONS BROTHERS |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md. |   | 13b. COUNTY<br>BALTO.   | 13c. CITY OR TOWN<br>OWINGS MILLS  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM COX   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>IDA M. CORNETT   |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>216-28-7239   |  | 17. INFORMANT<br>ADDRESS<br>Mr. WILLIAM E. SEWARD OWINGS MILLS, MD.                  |                                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Coronary Artery.

DUE TO, OR AS A CONSEQUENCE OF

(b) Respiratory Arrest.

DUE TO, OR AS A CONSEQUENCE OF

(c) Right Cerebral Vascular Accident.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-14</u> , 19 <u>86</u> , to <u>3-18</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3-18</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><u>Allan J. Chircus M.D.</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><u>3-18-86</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Allan J. Chircus M.D.</u>  |  | 22e. ADDRESS<br><u>Balt. County General Hosp.</u>  |   |

|  |                          |  |   |
|--|--------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL | 23b. DATE<br>MAR. 21, 86 | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKE VIEW MEMORIAL | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SYKESVILLE, MD. |
| 24. FUNERAL DIRECTOR<br>NAME<br>ELINE FUNERAL HOME     |                          | 25a. DATE REC'D. BY REGISTRAR<br>MAR 19 1986             |   |
| ADDRESS<br>REISTERSTOWN, MD.                           |                          | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>         |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BALTIMORE CO.

USA

CHESBON N.C.

YONG BROTHERS

ACTO. CO. VER. ROYAL.

INDALLSTON

506 BRYNMAWR AVE 21217

BALTO. CHING FILL

CORNETT

M. AN

COX

WILLIAM

BEARD CHING FILL

WILLIAM

506 - 21217

212

CURIAL - MAR. 21, 80 - LAKE VIEW MEMORIAL - SYKESVILLE, MD.

CLINE FUNERAL HOME - REISTERSTOWN, MD.

00-02104

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07126

1. FOR  
STATE  
REGISTRAR

|   |              |  |  |                               |                               |  |  |  |   |  |  |
|---|--------------|--|--|-------------------------------|-------------------------------|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John W. SHAUCK   |              |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED<br>19   |                               |                               | 2c. DATE<br>PRONOUNCED DEAD<br>Mar 30 1986   |  |  | 2d. HOUR<br>120   |  |  |
| 3. SEX<br>M   | 4. RACE<br>W | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>05/27/14 | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>71 YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS | IF UNDER 24 HRS.<br>HOURS MIN |  |  |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                               |                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> XX |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Essex  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |                               |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenence   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Noxell   |  |  |
| 13a. STATE<br>Md  |              |  | 13b. COUNTY  |                               |                               | 13c. CITY OR TOWN<br>Baltimore   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br>5605 Midwood Avenue 21212  |              |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter D. Shauck   |                               |                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Katherine Kirwin   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 10 3637   |                               |                               | 17. INFORMANT<br>Karen A. Cook   |  |  | ADDRESS<br>same   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |              |  |  |                               |                               |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |              |  |  |                               |                               |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                               |                               |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                               |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                               |                               | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |              |  |  |                               |                               |  |  |  |   |  |  |
| ACTUAL SIGNATURE<br><i>Paul F. Guerin</i>   |              |  | M.D. DEPUTY<br>1201 KUESSER AVE<br>BALTIMORE MD 21217  |                               |                               | DATE SIGNED<br>3/30/86   |  |  |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>PAUL F. GUERIN  |              |  | ADDRESS<br>1201 KUESSER AVE<br>BALTIMORE MD 21217  |                               |                               |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>Burial   |              |  | 23b. DATE<br>04/03/86  |                               |                               | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Balto. Co. Md.                        |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Burgee-Henss Funeral Home, 3631 Falls Rd 21211  |              |  |  |                               |                               | 25a. DATE REC'D. BY REGISTRAR<br>APR 01 1986   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>   |  |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))



00-01350

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07127

|   |  |   |  |   |  |  |  |  |  |  |  |   |  |   |  |   |  |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>MARY   |  | MIDDLE<br>E   |  | LAST<br>SHEPHERD   |  | 2a. DATE KNOWN OF DEATH  |  | MONTH<br>March   |  | DAY<br>20   |  | YEAR<br>1986  |  | 2b. HOUR<br>1P  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH<br>09<br>DAY<br>26<br>YEAR<br>1867  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>YRS.<br>67             |  | 7. IF UNDER 1 YR<br>MONTHS<br>DAYS   |  | 8. IF UNDER 24 HRS.<br>HOURS<br>MIN.   |  | 9. DATE PRONOUNCED DEAD<br>March 20 1986                                    |  | 10. HOUR<br>1P  |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary - Stebbins-Anderson |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS<br>1305 TAYLOR AVE                                      |  | 13b. CITY OR TOWN<br>BALTO  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 14. FATHER'S NAME<br>FIRST<br>Albert  |  | MIDDLE<br>J.  |  | LAST<br>Ellrich   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Agnes                   |  | MIDDLE<br>Rose   |  | LAST<br>Baynes   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>212-18-8198                                       |  | 17. INFORMANT<br>Carroll E. Ellrich-4704 Carroll Manor Rd.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute M.I.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>ASCD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>2 1/2 yrs</u> |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  | 22a. I certify that I took charge of the remains described above, held in custody <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from:<br>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22b. ACTUAL SIGNATURE<br><u>Charles F. Brown</u>             |  | 22c. TITLE SPECIFY<br>MEDICAL EXAMINER   |  | 22d. DATE SIGNED<br>3/20/86  |  | 22e. EXAMINER'S NAME<br>(TYPE OR PRINT)<br>ADDRESS                          |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                           |  | 23b. DATE<br>3-24-86  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial   |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Parkville, Balto., Md.  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc   |  | ADDRESS<br>1050 York Rd.<br>Towson, Md. 21204                |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 26 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John A. Burden</u>  |  | 25c. REGISTRAR'S NAME<br>John A. Burden                                     |  | 25d. REGISTRAR'S ADDRESS<br>Baltimore, Md.                                    |  |   |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #1A. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4-82

00-0132

26-9-55

STREET

00-0132

1000M

BALTIMORE

1000M





00-02064

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use on the burial transit permit. Then please remove carbonpapers, Pages 1 and 2. When the transit permit is filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, it is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified of such.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified of such.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  | XC 4159918   |  | REG. NO.   |  | 86 07128   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALFRED DELL SICKLES</b>   |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>MARCH 20, 1986</b>   |  | 2b HOUR<br><b>2:38 <sup>9</sup>AM</b>  |  |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>MARCH 31, 1907</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MICHIGAN</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>V.A. MEDICAL CENTER</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLAIMS CLERK</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>US Gov't</b>  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>  |  |  |  | 13b COUNTY<br><b>PRINCE GEORGE'S</b>   |  | 13c CITY OR TOWN<br><b>BOWIE</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>SAMUEL SICKLES</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LULA CHASE</b>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>4123 CROSSWICK TURN/20715</b>  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>W.W. II</b>  |  | 17 INFORMANT ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD.</b>  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE CARDIOMYOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>        |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b><br><b>5 YEARS</b><br><b>10 YEARS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>DIABETES MELLITUS, RENAL FAILURE, MALNUTRITION</b>  |  |  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Aurora C. Tan, M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-20-86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AURORA C. TAN, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Mar 24 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakemont Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Davidsonville, Maryland</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Beall Funeral Home</b>   |  |  |  | ADDRESS<br><b>16000 Annapolis Rd. Bowie, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |



Ball, Edward Henry  
Lowis, Maryland  
Mar 24 1966 Lakewood Cemetery  
Lanham, Maryland  
Mar 24 1966

065034

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 2 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth F. Simmons  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 1, 1986                   |   |   | 2b. HOUR<br>3:50p M  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 12 1890  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Md. 13b. COUNTY Balto. 13c. CITY OR TOWN Essex 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 928 Arncliffe Road 21221   |  |   |  |   |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Zell  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Foulk  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>141-54-4123 |   | 17. INFORMANT ADDRESS<br>Charles Buttiglieri 928 Arncliffe Road 21221   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Pneumococcal Pneumonia, renal failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0  |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from February 17 1986, to March 1 1986, that (we) last saw the deceased alive on March 1 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>GARY JOHNSON   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>March 1, 1986                                      |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GARY JOHNSON  |  |   |  |   | 22e. ADDRESS<br>9000 Franklin Square Drive 21237  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  |   | 23b. DATE<br>3/3/86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Pleasantville Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pleasantville New Jersey |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Connelly Funeral Home 300 Mace Ave. 21221  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 4 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>W. A. HARRISON - HARRISON                |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

180230

BOX COTTON LIDER

WILFRED DOWD



10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR  
REGISTRAR 5/1/86 rja

REG. NO. 07130

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUIS E SIMONE

2a. DATE KNOWN OF DEATH MONTH DAY YEAR 19 2b. HOUR M

3. SEX M 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 8 5 86 6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN 67 YRS. IF UNDER 1 YR. IF UNDER 24 HRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED NEVER MARRIED WIDOWED DIVORCED 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.

10. CITY OR TOWN OF DEATH Fullerton 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7554 Belair Rd. 21236 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance 12b. KIND OF BUSINESS OR INDUSTRY Ridgeway N.H.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES NO 13e. STREET ADDRESS 7554 Belair Rd. 21236

14. FATHER'S NAME FIRST MIDDLE LAST Louis Simone 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Viola Heinbuch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 217-14-5859 17. INFORMANT ADDRESS Louis Simone 1193 Convey Harbour Pasadena, Md. 21122

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIO DUE TO, OR AS A CONSEQUENCE OF UNASCULAR DISEASE (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO

21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes Accident Suicide Homicide Undetermined manner Inspection Inquiry and in my opinion

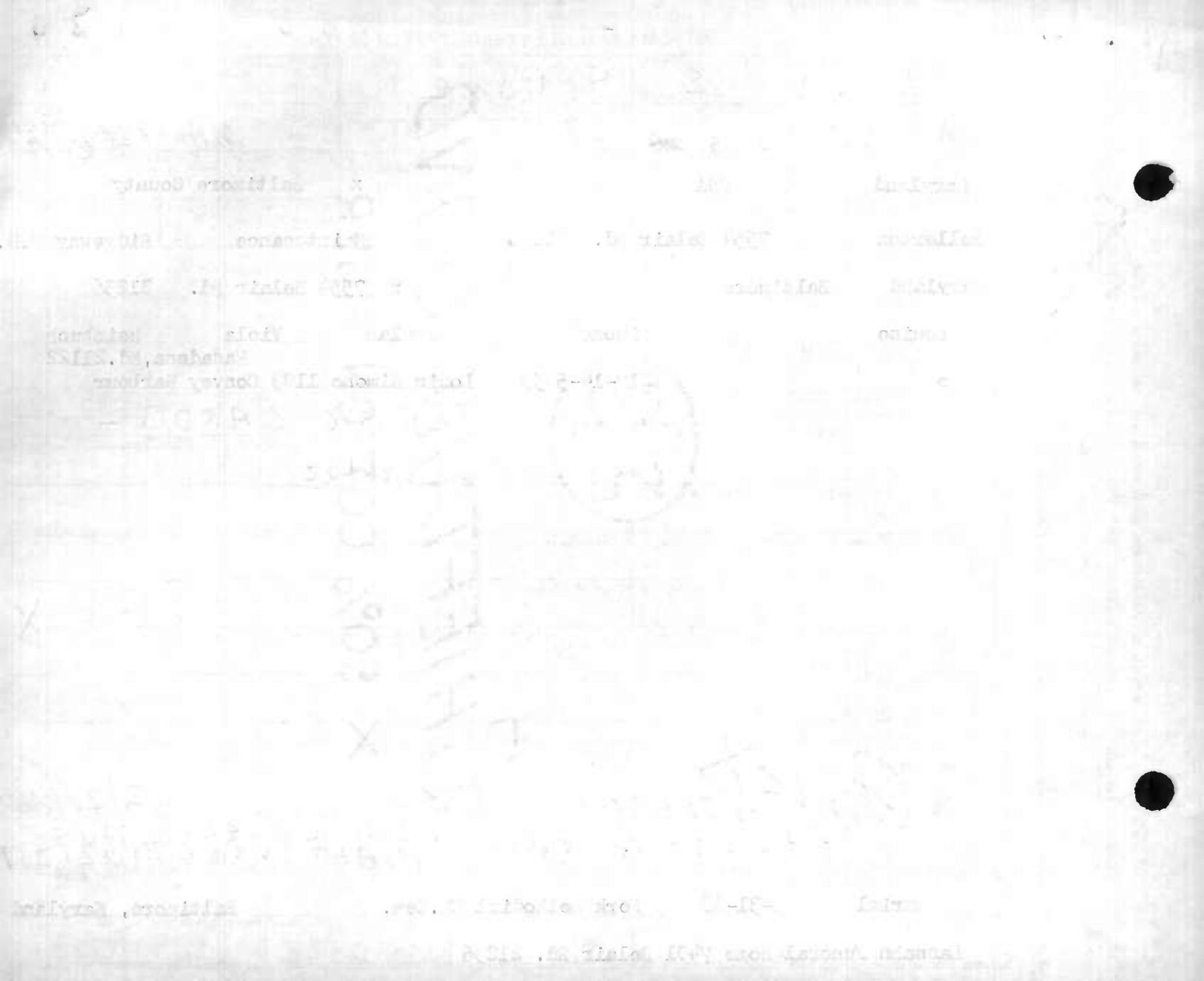
ACTUAL SIGNATURE PAUL K GUERIN M.D. TITLE (SPECIFY) REGISTRAR MEDICAL EXAMINER DATE SIGNED 3/28/86

EXAMINER'S NAME (TYPE OR PRINT) PAUL K GUERIN ADDRESS 1201 K RUEGER AVE BALTIMORE MD 21237

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 3-31-86 23c. NAME OF CEMETERY OR CREMATORY Fork Methodist Ch. Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland

24. FUNERAL DIRECTOR NAME Lassahn Funeral Home ADDRESS 7401 Belair Rd. 21236 25a. DATE REC'D. BY REGISTRAR APR 03 1986 25b. REGISTRAR'S SIGNATURE Davidson-Randell

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07131

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Howard Emory Simpson</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 30 86</b>                                   |  | 2b. HOUR<br>M<br><b>AM</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 12 12</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b><br>YRS. MONTHS DAYS HOURS MIN.          |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Fullerton</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>200 McCormick Avenue 21206</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.-Foreman</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B.G. &amp; E.</b>                            |   |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>200 McCormick Ave. 21206</b>                                 |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence R. Simpson</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary E. Enfield</b>                 |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>212-05-7461</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Carolyn R. Conkel 8234 Belair Rd. 21236</b>           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic CARCINOMA OF THE SKIN</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August - 7<sup>th</sup> 1985</b> to <b>MARCH 30<sup>th</sup> 1986</b> , that (I) (we) last saw the deceased alive on <b>MARCH 12<sup>th</sup> 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>A. Sergio Cassanego</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>4/1/86</b>  |   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. Sergio Cassanego MD. (243-0343)</b>  |  | 22e. ADDRESS<br><b>Good Samaritan Prof. Bldg. Balto., Md.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-2-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                        |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>APR 03 1986</b>   |   |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>7401 Belair Rd. 21236</b>   |   |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the state after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP







00-00679

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07132

REG. NO.

|   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John L. SIMPSON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 14, 1986</b>           |   |   | 2b. HOUR<br><b>11:01<sup>a</sup></b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 7 19</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Jamacia NY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AK Robins</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>21237</b>   |   | 13d. STREET ADDRESS / ZIP CODE<br><b>1416 Mt. Airy Rd. Balto. Md.</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Simpson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Livingston</b>  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 127-07-0073</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Ann Simpson 1416 Mt. Airy Rd. Balto. Md. 21237</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b). <b>Multiple myocardial infarctions</b><br>DUE TO, OR AS A CONSEQUENCE OF (c). <b>Severe coronary artery disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 10</b> , 19 <b>86</b> , to <b>March 14</b> , 19 <b>86</b> , that (we) lost<br>saw the deceased alive on <b>March 14</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>D.L. Sanderson M.D.</b>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.L. SANDERSON</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>3-17-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>James H. 7401 Belfair Rd. 21236</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>3.18.86</b>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>James H. 7401 Belfair Rd. 21236</b>  |  |  |  |   |   |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

BP

25000-00

RECEIVED

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07133

REG. NO.

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EVELYN Pauline Skinner</b> |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 7 86</b> |  |  | 2b. HOUR<br><b>13:27 PM</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6 27 21</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>64</b>                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE Co.</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BANDALLSTOWN</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. Co. GEN. HOSPT.</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED SOCIAL SECURITY</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO. Co.</b>  |   | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WORTHINGTON HURST</b>                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>JANET SKINNER</b>  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  |
| 16a. SOCIAL SECURITY NO.<br><b>235-36-5635</b>   |  | 17. INFORMANT ADDRESS<br><b>MR. STEVEN R. SKINNER OWINGS MILLS, MD</b>  |   |  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiopulmonary arrest due to**

DUE TO, OR AS A CONSEQUENCE OF

(b) **New myocardial infarction with ventricular**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Teary cancer and a new cca**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Hypertension Non-Insulin Dependent Diabetic Mellitus.**

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-17</b> , 19 <b>85</b> , to <b>3/7/86</b> , that (I) (we) last saw the deceased alive on <b>3/7/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>R.M. Shah M.D.</b>  |  |  |  | DEGREE  |  | 22c. DATE SIGNED <b>3/7/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.M. SHAH</b>  |  |  |  | 22e. ADDRESS <b>8507 CIREKTY RD. RANDALLSTOWN, MD 21133</b>                       |  |   |  |

|  |  |                                 |  |  |  |   |  |
|--|--|---------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                       |  | 23b. DATE<br><b>MAR. 11, 86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LAKEVIEW PARK</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>SYKESVILLE, MD.</b> |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>ELINE FUNERAL HOME REISTERSTOWN, MD.</b> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Friedman-Randall</b>        |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. It should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked with injury, or other traumatic event, the medical examiner will be notified and a necropsy will be required.

071135

071135

BALTIMORE CO.

X

USA

WEST VIRGINIA

RETIRED SOCIAL SECURITY

BALTO. CO. GEN. HOSPT.

1000 CALVIN ROAD 21202

BALTO. CO. CATONSVILLE

KINER

JANET

HURST

ORTHINGTON

231-25-1000 W. STIVEN R. KINER WINGS, ILL.

110

LYNCHVILLE, N.C.

PARK, LAKESIDE PARK

FOOTBALL

CLUB, BUREAU HOME, REISTERSTOWN, MD.

00-00285

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH86 07134  
REG. NO.

|   |  |  |   |   |                              |  |  |
|---|--|--|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>George W. Snyder</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-11-86</b> |   | 2b. HOUR<br><b>2:00 A.M.</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-19-10</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Towson Balto. CO MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Joseph Hospital</b>   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.-Equip. Oper.</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Barhardt &amp; May</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN   |                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilbur Snyder</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia Thompson</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |                              | 16b. SOCIAL SECURITY NO.<br><b>215-09-6864A</b>  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Elsie K. Snyder 6805 Golden Ring Rd. 21237</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>RENAL FAILURE</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>HYPERGLYCEMIA.</b>   |  |  |   |   |                              |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2314 E. Joppa Rd. Baltimore, Maryland</b>   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> , 19____, to <b>3-11-86</b> , that (I) (we) lost saw the deceased alive on <b>3-10-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>Ruben S. Sebastian</b>   |  | DEGREE<br><b>M.D.</b>  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |                              | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ruben S. Sebastian, MD (668-2211)</b>   |  | 22e. ADDRESS<br><b>2314 E. Joppa Rd. Baltimore, Md.</b>  |   |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-14-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>   |  | ADDRESS<br><b>7401 Belair Rd. Balto. MD 21236</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>   |                              | 25b. REGISTRAR'S SIGNATURE<br><b>E. Davidson-Randall</b>   |  |

MEDICAL CERTIFICATION

99

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-00271

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07135

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><i>Julia Davis Crow Small</i>   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><i>3-13-86</i>   |  | 2b HOUR<br><i>124pm</i>   |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>White</i>   |  | 5 DATE OF BIRTH<br>MO DAY YEAR<br><i>August 22, 1901</i>                            |  |
| 6a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Michigan</i>   |  | 6b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 6 AGE (IN YEARS) (BIRTHDAY)<br><i>84</i> YRS.                                       |  |
| 7a CITY OR TOWN OF DEATH<br><i>Towson</i>   |  | 7b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><i>Stella Maris Hospice</i>          |  | 8 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County, MD.</i>                 |  |
| 9 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><i>Maryland</i> |  | 13b COUNTY<br><i>Baltimore</i>   |  | 13c CITY OR TOWN<br><i>Monkton</i>  |  |
| 10 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Henry Edgar Crow</i>  |  | 11 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Nellie NMN Davis</i>                        |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i> |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><i>Homemaking</i>   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS / ZIP CODE<br><i>1445 Monkton Road, #21111</i>                   |  |
| 14a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 14b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>184-40-3149</i>                   |  | 15 INFORMANT<br>ADDRESS<br><i>Cynthia S. Tillman 320 Jodyway, Timonium 21093</i>    |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>3/11 1986</i>    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/11</i> to <i>3/13</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3/13</i> <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes, did) did not view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Eddie Nakuda</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Eddie Nakuda, M. D.</i>   |  |  |  | 22e. ADDRESS<br><i>2300 Dulaney Valley Rd, Towson, Md. 21204</i>   |  |  |  |

MEDICAL CERTIFICATION

|  |  |                            |  |   |  |  |  |
|--|--|----------------------------|--|---|--|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br><i>Burial</i>        |  | 23b DATE<br><i>3/15/86</i> |  | 23c NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Cemetery</i> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Woodlawn, Baltimore Co., Md.</i> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>Martin D. Lawson</i> |  |                            |  | 25a DATE REC'D. BY REGISTRAR<br><i>MAR 14 1986</i>            |  |  |  |
| 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>        |  |                            |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the aid of the attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



1. [illegible]  
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98. [illegible]  
99. [illegible]  
100. [illegible]



071026

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8607136  
REG. NO.

|  |  |   |   |   |  |   |  |   |  |  |
|--|--|---|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANCES Gertrude SMITH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 9, 86</b> |   |  | 2b. HOUR<br><b>4:25 PM</b>  |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-11-1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                     |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dietician</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>          |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Md.</b> |  |   |   | 13c. CITY OR TOWN<br><b>Sykesville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>704 Church St. 21154</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |   | 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT ADDRESS   |  |   |  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic obstructive lung disease</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **no**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 13, 1986</b> to <b>March 9, 1986</b> , that (I) (we) last saw the deceased alive on <b>March 9, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Sharon Pourmotabbed, M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-9-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GHASSEM POURMOTABBED</b>   |  |  |  | 22e. ADDRESS<br><b>Balto. Co. Gen. Hospital</b>  |  |   |  |

|  |  |                             |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPONSOR)<br><b>Burial</b>                  |  | 23b. DATE<br><b>3-11-86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Oakland Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Harry W. Haight Sykesville, Md.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 10 1986</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                 |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21202

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 will be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



00-01628

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8607137

|   |  |   |   |  |  |   |  |  |   |                                       |                                    |   |  |  |  |
|---|--|---|---|--|--|---|--|--|---|---------------------------------------|------------------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN JOSEPH SMITH  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 27, 1986 |  |  | 2b. HOUR<br>5:45a <sub>M</sub>  |  |  |   |                                       |                                    |   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 6, 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80<br>YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |                                       |                                    |   |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesperson |                                       |                                    |   |  |  |  |
| 13. CITY OR TOWN OF DEATH<br>Baltimore  |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8820 Blairwood Ct. Apt. A4 |   |  |  | 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>15a. STATE<br>Maryland |  | 16. KIND OF BUSINESS OR INDUSTRY<br>Dept. Store  |   | 17. 12b. KIND OF BUSINESS OR INDUSTRY |                                    |   |  |  |  |
| 18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>18a. STATE<br>Maryland |  | 19. COUNTY<br>Baltimore   |   | 20. CITY OR TOWN<br>Baltimore  |  | 21. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 22. STREET ADDRESS / ZIP CODE<br>8820 Blairwood Ct. 21236  |   |                                       | 23. 15b. STREET ADDRESS / ZIP CODE |   |  |  |  |
| 24. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Smith   |  |   |   | 25. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nellie Nottrey  |  |   |  | 26. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |   |                                       |                                    | 27. 16b. SOCIAL SECURITY NO.<br>187-10-3495 |  |  |  |
| 28. 17. INFORMANT<br>ADDRESS<br>21236   |  |   |   | 29. 17. INFORMANT<br>ADDRESS<br>21236  |  |   |  | 30. 17. INFORMANT<br>ADDRESS<br>21236  |   |                                       |                                    | 31. 17. INFORMANT<br>ADDRESS<br>21236       |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Chronic Obstructive Pulmonary Disease

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22. I certify that (1) (this hospital) attended the deceased from JAN 23, 1986, to MARCH 27, 1986, that (1) (we) last saw the deceased alive on FEB 17, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br>Walter A. Welzant, M.D.   |  |  |  | 22b. DEGREE<br>MD  |  | 22c. DATE SIGNED<br>Mar. 27, 1986   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Walter A. Welzant, M.D.  |  |  |  | 22e. ADDRESS<br>6100 York Rd.  |  |   |  |

|   |  |                            |  |  |  |   |  |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Mar. 31, 1986 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |  |
| 24. FUNERAL DIRECTOR<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214 |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 31 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                   |  |



00-00278

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

07138

REG. NO.

|   |  |  |  |  |                           |  |
|---|--|--|--|--|---------------------------|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Robert SMITH</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 9, 1986</b>           |  | 2b HOUR<br><b>1:45P M</b> |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 12 1907</b>                                       |                           |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                           |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |  |                           |  |
| 10 CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b>           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer-Beth. Steel</b> |                           |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |                           |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>Md.</b> 13b COUNTY <b>Balto.</b> 13c CITY OR TOWN <b>Essex</b>   |  |  |  |  |                           |  |
| 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e STREET ADDRESS / ZIP CODE<br><b>8810 Golden Tree Lane 21221</b>  |  |  |                           |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adam Smith</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna unknown</b> |  |                           |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b SOCIAL SECURITY NO.<br><b>213-07-1918</b>  |  | 17 INFORMANT ADDRESS<br><b>Helen Schmitt 8810 Golden Tree Lane 21221</b>                       |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cardiovascular accident, Atrial fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |                           |  |
| MEDICAL CERTIFICATION   |  |  |  |  |                           |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                           |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |  |  |                           |  |
| 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                           |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |  |
| 22a I certify that <b>6</b> (this hospital) attended the deceased from <b>March 2</b> , 19 <b>86</b> , to <b>March 9</b> , 19 <b>86</b> , that <b>1</b> (we) last saw the deceased alive on <b>March 9</b> , 19 <b>86</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>1</b> (we) (did) (did not) view the body after death.  |  |  |  |  |                           |  |
| 22b SIGNATURE<br><b>Gary Johnson</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c DATE SIGNED<br><b>3/9/86</b>   |                           |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gary Johnson</b>   |  | 22e ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |  |  |                           |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>3/11/86</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                   |                           |  |
| 23d LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>Rossville Balto. Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>   |  |  |                           |  |
| 25a DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>  |  | 25b REGISTRAR'S SIGNATURE<br><b>L. A. Anderson-Rodriguez</b>   |  |  |                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. This place name is carbon paper. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, greater traumatic event, the medical examiner must be notified at once.

BP

00-00378

1968

25

00-00107

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH |  | 8607139<br>REG. NO.  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Carl John Sodergren   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>March 6, 1986  |  | 2b. HOUR<br>1am M                            |
| 3 SEX<br>Male   |  | 4 RACE<br>White  | 5. DATE OF BIRTH MONTH DAY YEAR<br>August 30, 1903 |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82<br>YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  | 10 CITY OR TOWN OF DEATH<br>Pikesville   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)<br>415 South Road  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. Gas&Elect  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.  | 13c. CITY OR TOWN<br>Pikesville                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Emil H. Sodergren   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Laura Ringbom                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO<br>212-05-6693   |  | 17 INFORMANT P.O. Box 632<br>Grace Patton Brooklandville, Md. 21022  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>Mild essential hypertension</u>  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>none</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>none</u>                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><u>none</u>  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 9, 1981</u> to <u>March 19, 1986</u> that (I) (we) last saw the deceased alive on <u>Dec 22</u> 19 <u>1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                       |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Charles E. Ellicott M.D.</u>   |  | DEGREE   |  | 22c. DATE SIGNED<br>3-7-1986   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES E. ELLICOTT MD   |  | 22e. ADDRESS<br>1134 York Rd Lutherville MD 21093                                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 8, 1986  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Woodlawn, Balto., Md.  |  | 24 FUNERAL DIRECTOR NAME ADDRESS<br><u>W. E. Ellicott</u> Owings Mills, Md.          |  |  |  |
| 25a. DATE RECD. BY REGISTRAR<br>MAR 10 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |  |  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 4 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY E. SPRINGER</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3/14/86</b>                                      |   | 2b. HOUR<br><b>11A</b> M   |
| 3 SEX<br><b>F FEMALE</b>  | 4 RACE<br><b>W WHITE</b>  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2/10/99</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b> MD                                 |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>GLYNDON, MD.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BENT NURSING HOME</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRACTICAL NURSE</b> | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD.</b>  |   | 13b. COUNTY<br><b>BALTIMORE</b>  | 13c. CITY OR TOWN<br><b>REISTERSTOWN</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>12021 Reisterstown Rd</b>  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES SWITZER</b>   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE SMITH</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO<br><b>220-46-0340</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>14 GLYNDON AVE<br/>GLYNDON MD. 21071</b>                          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vasculature Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b><br><b>Years</b> |   |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 15</b> 19 <b>84</b> to <b>March 14</b> 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>March 14</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>C. E. McWilliams MD</b>  |   | 22c. DATE SIGNED<br><b>3-14-86</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. E. McWilliams MD</b>                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>3/17/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ALL SAINTS CEMETERY REISTERSTOWN, BALTO. MD.</b>       |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>ELINE FUNERAL HOME, REISTERSTOWN, MD.</b>   |   | 24b. ADDRESS<br><b>11904 Reisterstown Rd, Reisterstown MD 21136</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 17 1986</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John T. Williams</b>   |   |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

EMALE

WHITE

U.S.A.

SWITZER

DONALD WILSON

14 GLYNDON AVE  
GLYNDON, D. 21021

10

BURIAL 277700 ALL SAINTS CEMETERY REISTERSTOWN, BALTO. MD.  
ELINE FUNERAL HOME, REISTERSTOWN, MD.

00-01420

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07141

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEROY E. STAPF, SR.</b>  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 24, 1986</b>  |  | 2b HOUR<br><b>7:48A<sub>M</sub></b>  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 30, 1904</b>  |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>   |  | 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8009 YORK ROAD APT B6</b>                  |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERVISOR</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>POST OFFICE</b>   |  | 13a STREET ADDRESS / ZIP CODE<br><b>8009 YORK ROAD APT.B6 21204</b>  |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>BALTIMORE</b>   |  | 13c CITY OR TOWN<br><b>TOWSON</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES J. STAPF</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MINNIE NAGEL</b>   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |
| 16b SOCIAL SECURITY NO<br><b>216-24-3544</b>  |  | 17 INFORMANT<br><b>LAURA S. STAPF</b>  |  | ADDRESS<br><b>8009 YORK RD. B6 21204</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of Colon &amp; Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>2 year</u><br>Approximate Interval Between Onset and Death<br><u>Sudden</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |
| 19a DATE OF OPERATION<br><u>3-22-86</u>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Colon &amp; Lung</u>   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |
| 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>19</u>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |
| 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a I certify that (I) (this hospital) attended the deceased from <u>6-1984</u> to <u>3-24-86</u> , that (I) (we) most saw the deceased alive on <u>3-22-1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b SIGNATURE<br><u>Keith A. Manley</u>   |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>3-24-86</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEITH A. MANLEY, M.D.</b>   |  | 22e ADDRESS<br><b>1818 POT SPRINGS ROAD 252-1300</b>   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>MARCH 27, '86</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEMETERY</b>  |  |
| 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY, MD</b>  |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.</b>   |  |  |  |
| 25a DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>  |  | 25b REGISTRAR'S SIGNATURE<br><u>William E. Johnson</u>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

204 COLON 10102

00-01410

00-01410

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 7 1 4 2

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MILDA S. STEELBERG</b>                  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>03/20/86</b>                |  |  | 2b HOUR<br><b>7:30 a.m.</b>   |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 01 05</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b> |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                        |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b KIND OF BUSINESS OR INDUSTRY                            |  |
| 13a STATE<br><b>Md.</b>  |  |   | 13b COUNTY<br><b>Baltimore</b>                                       |  | 13c CITY OR TOWN   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Feinhard</b>                    |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lina Meinhold</b> |  |  | 13e STREET ADDRESS / ZIP CODE<br><b>17 Madeline Ave. 21206</b>                      |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |   | 16b SOCIAL SECURITY NO.<br><b>212-50-0086</b>                        |  | 17 INFORMANT<br>ADDRESS<br><b>Duane Steelberg 9006 Carlisle Ave.</b> |   |  |   |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Pulmonary Embolus,**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Lymphoma**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**1 hour****26 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**Congestive Heart Failure**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a DATE OF OPERATION<br><b>Nov</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>3/24/81</b> to <b>3/8/86</b> , that (2) (we) last saw the deceased alive on <b>3/8/86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) not view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Luke E. Terry, Jr.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-20-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Luke E. Terry, Jr., M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>9055 Chevrolet Dr., Ellicott City, MD. 21043</b>  |  |  |  |

MEDICAL CERTIFICATION

|  |  |                            |  |   |  |   |  |
|--|--|----------------------------|--|---|--|---|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                       |  | 23b DATE<br><b>3/24/86</b> |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b> |  |                            |  | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAR 26 1986 Luke Davidson-Randall</b> |  |   |  |

St. Lawrence County

X

17 Maceline Ave. 21206

Albany

212-53-1485 - a. Albany 10 C. State Ave.



212-53-1485



212-53-1485

212-53-1485

During 1974, Bureau of the State, Albany

St. Lawrence County, New York

00-00673

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 4 3

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IDA E. STEIN FORT</b>                         |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-18-86</b>                         |   |  | 2b. HOUR<br><b>4<sup>10</sup> AM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>CAUC.</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-30-03</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. COUNTY</b> MD.                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT INQUIRY, CLERK, GIVE STREET ADDRESS)<br><b>BALT. COUNTY GEN. HOSP.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |   |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7833 Fairgreen Road 21222</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward N. Forrest</b>                      |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Delia Wright</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-07-5914</b> |   |  | 17. INFORMANT<br>ADDRESS<br><b>Mollie D. Magruder Same as 13e</b>                               |  |  |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b> |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPSIS</b>                                |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC UTI</b>                           |  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **DM, ASCVD**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. ALTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED:<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-17</b> 19 <b>86</b> to <b>3-18</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>3-18</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Charles Schwartz MD</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3-18-86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES SCHWARTZ MD</b>  |  |  |  | 22e. ADDRESS<br><b>BALT. COUNTY GEN. HOSP</b>  |  |  |  |

|   |  |                               |  |   |  |   |  |
|---|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/21/1986</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens Of Faith</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</b> |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1986</b>           |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Rendell</b>                   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

3-12-44

ST. LOUIS, MO.

TO :

CHIEF, ST. LOUIS OFFICE

FROM :

ST. LOUIS

RE: [illegible]

[illegible]

[The body of the letter contains several paragraphs of extremely faint, illegible text. It appears to be a standard memorandum format with a subject line and a body of text.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   | REG. NO.   |  |
|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  |   |   | 07144  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>DAVID VANRENSSELAER STICKLE</b>  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR 3 4 1986 7 <sup>50</sup> A.M.                                 |  |
| 3 SEX <b>M.</b>  | 4 RACE <b>CAUCASIAN</b>  | 5. DATE OF BIRTH MONTH DAY YEAR 6 11 1916   |   | 6 AGE (IN YEARS LAST BIRTHDAY) 69 <del>70</del> YRS  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>   | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO</b> County MD.                                    |  |
| 10 CITY OR TOWN OF DEATH <b>Towson</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella MARIS</b> |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>News Director</b>           |  | 12b KIND OF BUSINESS OR INDUSTRY <b>T.V.-WMAR</b>  |
| 13a STATE <b>Md</b>  | 13b COUNTY <b>BALTO.</b>   | 13c CITY OR TOWN <b>TIMONIUM</b>  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET ADDRESS / ZIP CODE <b>2305 Wuthering Rd 21093</b>                                   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES Willard STICKLE</b>  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kathleen WRIGHT</b>                            |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>Yes</b>   |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE DATES) <b>WWII 126-10-9106</b>  |   | 17. INFORMANT ADDRESS <b>Stella Maris Hospice 2309 Dulaney Valley Rd. Stella MARIS Records</b> |  |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute M.I.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>   |  |   |   |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                          | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>MARCH 14 1985</b> to <b>MARCH 4 1986</b> , that (I) (we) last saw the deceased alive on <b>2/19 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                               |  |   |   |  |  |
| 22b SIGNATURE <b>Eddie Nakhuda</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |   | 22c DATE SIGNED  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  | 23b DATE <b>3-5-86</b>  | 23c NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>   |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>  |
| 24 FUNERAL DIRECTOR <b>Mitchell- Wiedefeld Home 6500 York Road 21212</b>   |  |   |   | 25a DATE REC'D. BY REGISTRAR <b>MAR 11 1986</b> 25b REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |   |   |   |  |  |  |  |   |
|--|---|---|---|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |  |   |
| BABY GIRL STICKLEY   |   |   | 03 07 '86   |  |  | 7:25A M  |  |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  | IF UNDER 1 YEAR  |  | IF UNDER 72 HRS   |
| FEMALE   | White   | 03 07 '86   | YRS MONTHS DAYS   |  |  | HOURS MIN.   |  | 2 45  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |   |
| Maryland   | U.S.A.  |   | BALTIMORE COUNTY, MD  |  |  |  |  |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |
| TOWSON   | GREATER BALTIMORE MEDICAL CENTER  |   | None  |  |  |  |  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   | 13b. INSIDE CITY LIMITS?  |  |  | 13c. STREET ADDRESS / ZIP CODE   |  |   |
| Maryland Carroll Westminister  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 27 East Main St. 21157   |  |   |
| 14. FATHER'S NAME  |   |   | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |   |
| JEFF SPENCER STICKLEY  |   |   | CONNIE FRANCES HONEYCUTT  |  |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |   | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS  |  |   |
| No   |   |   | None  |  |  | Jeffery S. Stickley, Westminister, Md.   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEVERE IMMATURITY</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |   |   |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |
| 19a. DATE OF OPERATION   |   |   |   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |
| 20a. AUTOPSY?  |   |   |   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |   |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>86</u> , to <u>3/7</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>3/7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |  |  |   |
| 22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u>   |   |   |   |  |  | 22c. DATE SIGNED<br><u>3/7/86</u>  |  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VIRMA TORRES, M.D.  |   |   |   |  |  | 22e. ADDRESS<br>GBMC 6701 N. CHARLES STREET 21204                              |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                     |  |   |
| Burial   |   | 3/9/86  |   | Indian Mound Cemetery  |  | Romney Hampshire WV  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME Keith S. Shaffer ADDRESS<br>Shaffer Funeral Home, Romney, WV 26757  |   |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 12 1986                                   |  |   |

MEDICAL CERTIFICATION

100-100000



100-100000

00-0211

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 4 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |                              |  |  |   |  |                                    |  |
|---|------------------------------|--|--|---|--|------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)       |                              | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                              |  | 2b. HOUR                           |  |
| BERTHA ELIZABETH STOEBCNER                |                              |  |  | MARCH 27, 1986  |  | M                                  |  |
| 3. SEX                                    | 4. RACE                      | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS |  |
| Female                                    | White                        | March 22, 1888   |  | 98  |  | MONTHS DAYS HOURS MIN.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |                                    |  |
| Maryland                                  | USA                          |  |  | Baltimore County MD.  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH                 |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Towson                                    |                              | St. Joseph Hospital  |  | Homemaker   |  |                                    |  |

|   |  |                          |  |  |  |  |  |  |  |
|---|--|--------------------------|--|--|--|--|--|--|--|
| 13a. STATE  |  | 13b. COUNTY              |  | 13c. CITY OR TOWN                          |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / 710 CODE 21030             |  |
| Maryland  |  | Baltimore                |  | Cockeysville                               |  |  |  | Warren Lodge Apts., Warren Rd. Cockeysville, Md. |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST                               |  |                          |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |  |  |  |  |  |
| Herman E. Vogler, Sr.   |  |                          |  | Elizabeth J. Lind                          |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |  | 16b. SOCIAL SECURITY NO. |  | 17. INFORMANT ADDRESS                      |  |  |  |  |  |
| No  |  | 220-46-4544              |  | Clarice E. Kroneberger - same              |  |  |  |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Congestive Heart Failure  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last         |  |  |  |
| (b)   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c)   |  |  |  |

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |
| 22. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (1) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did not) saw the body after death. |  |  |  |   |  |   |  |
| 22a. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |
| Paul Rivas, M.D.   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 3-31-86   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |
| Paul Rivas, M.D.   |  | 3421 Sweet Air Rd., Phoenix, Md. 21131   |  |   |  |   |  |

|   |  |               |  |                                    |  |   |  |
|---|--|---------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)       |  | 23b. DATE     |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |
| Burial  |  | 3/31/86       |  | Loudon Park                        |  | Baltimore City, Maryland                |  |
| 24. FUNERAL DIRECTOR NAME                       |  | ADDRESS       |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE              |  |
| Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 |  | 6500 York Rd. |  | APR 01 1986                        |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Lodge Apts., Warren Rd.  
Cokeville, W. Va. 26030

Mr. J. M. Smith  
1 Grand St.

Corporate Trust Fund

Wm. H. Smith  
1944

Wm. H. Smith  
1944

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, only the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal (IMPORTANT: If item 21 is marked on item 18, when any injury, or other traumatic event, the medical examiner must be notified and signed).

DHMH - 16 60M 7/B4  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

0 7 1 4 7

1 - FOR  
STATE  
REGISTRAR

REG. NO.

065036

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Paul James Straszynski</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>1</b> YEAR <b>1986</b>  |  | 2b. HOUR<br><b>4:45p</b> M   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>Jan.</b> DAY <b>17</b> YEAR <b>1897</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORK OCCUPIED)<br><b>Retired-Security</b>  | 12b. KIND OF BUSINESS OR<br><b>Domono Sugar</b>                                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Essex</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS / ZIP CODE<br><b>205 Mace Ave. 21221</b>                         |  |
| 14. FATHER'S NAME<br>FIRST <b>Joseph</b> MIDDLE <b>Straszynski</b> LAST <b>Straszynski</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Florentina</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>WW I 218-10-5650</b>   | 17. INFORMANT<br>ADDRESS<br><b>Dorothy Straszynski 205 Mace Ave. 21221</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock Secondary to Massive Anterior Septal Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>History Of Alcoholism</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 26</b> , 19 <b>86</b> , to <b>March 1</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>March 1</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Calvin R. Rugg</i>  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>March 1, 1986</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Calvin Rugg</b>  |  |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/5/86</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>  |  | 23d. LOCATION<br><b>Rossville Baltimore Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Connolly Funeral Home 300 Mace Ave. 21221</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 4 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |

MEDICAL CERTIFICATION

002036



20% COLLECTOR'S EDITION

UNIVERSITY MICROFILMS



071222

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 4 8

REG. NO.

|   |  |   |   |   |   |  |   |  |   |  |
|---|--|---|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Carl</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 6, 1986</b>                   |   |   | 2b. HOUR<br><b>6:48 a.m.</b>   |   |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 20, 1912</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>73</b>                                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sq. Hospital</b> |   |   |   | 12a. OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Forger</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel Mill</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Essex</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>219 S. Marlyn Ave. 21221</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard Stubenrauch</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213 07 9598</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Evelyn M. Ray, Friend Balto., Md. 21221</b>            |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>  |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEVERE Chronic obstructive pulmonary disease (COPD)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |   |   |  |   | <b>5 yrs</b>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)<br><b>SEVERE Congestive heart failure, CVA.</b>  |  |   |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3/6/86</b><br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)        |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5400 Old Court Road 21133</b> |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/6/86</b> 19 to <b>3/6/86</b> 19, that (I) (we) lost<br>saw the deceased die <b>3/6/86</b> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Naeem Gauhar</b>   |  |   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br><b>3/6/86</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Naeem Gauhar, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>5400 Old Court Road 21133</b>  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/8/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Memorial Gardens</b>              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                             |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdinski Funeral Home PA</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 10 1986</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caution labels. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

June 24, 1952

1952

XX

General

Carroll, George W. 1000/1000

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00-002700

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

07149

|   |  |   |   |   |  |  |   |   |  |  |
|---|--|---|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHARLES MARION STUMPNER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 13, 1986</b>                  |   |  | 2b. HOUR<br><b>2:00 A.M.</b>   |   |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 10 20 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                      |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Woodlawn</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2100 Northland Road</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Clerk</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O. Railroad</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Woodlawn</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>2100 Northland Road 21207</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel Stumpner</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Jean Lynn</b>    |   |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>705-10-0103</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Nilsson Stumpner Same as # 13</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>lung Cancer</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mo</b> |  |   |   |   |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)           |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3/13 19 86</b>                   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/28</b> 19 <b>86</b> to <b>3/13</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>3/11</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>William C. Waterfield M.D.</b>   |  |   |   |   |  | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>3/13/86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William C. Waterfield M.D.</b>  |  |   |   |   |  | 22e. ADDRESS<br><b>900 Caton Avenue, Baltimore, MD.</b>                                  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>3/17/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Maryland</b>                          |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b><br><b>1630 Edmondson Avenue, Catonsville, MD. 21228</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randell</b>  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

07300-00



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP  
DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

066189

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  | REG. NO.                                     |  |
|--|--|---|--|---|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | 2a. DATE OF DEATH   |   |  |  |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN DOUGLAS STURGEON  |  |   |  |   | March 4, 1986   |   |  |  |  | 1:00A M                                      |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 4, 1917  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8 N. Beaumont Avenue |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor-Mail             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Room - Maryland Cup. Co.  |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Catonsville  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8 N. Beaumont Avenue 21228   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John S. Sturgeon  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Edna Bargar         |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-07-0687  |  | 17. INFORMANT ADDRESS<br>Helen L. Sturgeon Same as # 13   |   |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic cancer of the larynx</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><u>Aug 82</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>laryngeal cancer</u>   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 29</u> , 19 <u>85</u> , to <u>Mar 4</u> , 19 <u>86</u> , that (I) (we) lost<br>saw the deceased alive on <u>2/20/86</u> , 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>William C. Gray M.D.</u>  |  |   |  |   |   |   |  |  |  | 22c. DATE SIGNED<br><u>3/4/86</u>            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Gray M.D.   |  |   |  |   | 22e. ADDRESS<br>Baltimore, MD.<br>University Of Maryland Hospital |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3/6/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD, 21228   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 5 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Anderson Randall</u>   |  |  |  |

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00-02199

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edward Franklin Sudduth</b>                 |  |   | 2a. DATE OF DEATH<br>MONTH <b>March</b> DAY <b>25</b> YEAR <b>1986</b>                    |   | 2b. HOUR<br><b>0450</b> M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>May</b> DAY <b>5</b> YEAR <b>1918</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                       |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Gen. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Superintendent</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Maintenance</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Balto.</b>  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br><b>28 Brookbury Dr. Apt. 2C</b> <b>21136</b> |
| 14. FATHER'S NAME<br>FIRST <b>Lemiel</b> MIDDLE <b>Sudduth</b> LAST <b></b>        |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Matilda</b> MIDDLE <b>B.</b> LAST <b>Edwards</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b> | 16b. SOCIAL SECURITY NO.<br><b>213-28-4848</b>   | 17. INFORMANT<br><b>Olliemae Sudduth</b> ADDRESS <b>28 Brookbury Dr. 2C Reisterstown, Md.</b>   |   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **Acute Myocardial INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**Chronic obstructive Pulmonary Disease**

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/31/1985</b> to <b>3/6/1986</b> , that (I) (we) lost saw the deceased alive on <b>3/6/1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>GARY A. MANKO</b>  |  | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>3-25-1986</b>   |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GARY A. MANKO</b>   |  | 22b. ADDRESS<br><b>11 E Chestnut Hill Ln, REISTERSTOWN, MD 21136</b>                 |  |

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>                        | 23b. DATE<br><b>Mar. 27, 1986</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b> | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY <b></b> STATE <b></b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>H. J. Schaubert</b> ADDRESS <b>Swings Mills, Md.</b> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>             | 25b. REGISTRAR'S SIGNATURE<br><b>Jane M. ...</b>                                      |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

March 21, 1916 0-20 Franklin

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Leicester County

Leicester County Hospital 1917-1918

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 0 7 1 5 2  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy E. Summers   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 8 86                          |   |  | 2b. HOUR<br>M  |  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 23 23   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. County MD.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>126 Nunnery La. - Apt. A |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Secretary-Fidelity & Dep. Co.  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCY BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 13e. STREET ADDRESS / ZIP CODE<br>Balto., Md. #28<br>126 Nunnery La. - Apt. A |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph A.   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Sarah E. Fitzer            |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br>Joseph A. Summers  |  |   | ADDRESS<br>126 Nunnery La. - Balto., Md.                               |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) ASVD - possible pulmonary embolism<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |  |   |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>In Rm   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8:00 PM 8-6-86, to 3:10 PM 8-6-86, that (I) (we) last saw the deceased alive on 8-6-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>[Signature]   |  |   | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>3/10/86  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G. Truman  |  |   | 22e. ADDRESS<br>BALTO. NAT'L FIRE # 21219                              |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Mar. 11, 1986   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |  |   |  |
| 24. FUNERAL DIRECTOR<br>G. Truman   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 10 1986                           |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |   |  |

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203-00109-1102

00-88055

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                              |  |
|--|--|---|--|---|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BENNIE LARRY SWENSEN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 11, 1986</b> |   | 2b. HOUR<br><b>3:05 P.M.</b> |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 5, 1933</b>                             |                              |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TEXAS</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                              |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>  |  |   |                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS HOSPICE</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROFESSOR</b>  |                              |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>EDUCATION</b>  |  | 13a. STREET ADDRESS / ZIP CODE<br><b>208 MARYLAND AVENUE 21204</b>  |  |   |                              |  |
| 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13c. CITY OR TOWN<br><b>TOWSON</b>  |  | 13d. STREET ADDRESS / ZIP CODE<br><b>208 MARYLAND AVENUE 21204</b>                    |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>AUGUST JOHN SWENSEN</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CORA L.</b>   |  |   |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(DATE OF UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 16b. SOCIAL SECURITY NO.<br><b>454-50-0416</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>ALVIE L. HASTE TOWSON, MD 21204</b>                    |                              |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Large cell carcinoma of the</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung metastatic To pleura and brain</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> |  |   |  |   |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |                              |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                              |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                     |                              |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                |                              |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22. I certify that (I) (this hospital) attended the deceased from <u>December 13, 1985</u> , to <u>March 10, 1986</u> , that (I) (we) last saw the deceased alive on <u>March 9, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not re-view the body after death. |  |   |                              |  |
| 22a. SIGNATURE<br><u>Mayer Gorbaty</u>   |  | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>3/12/86</u>  |                              |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAYER GORBATY, M.D.</b>  |  | 22e. ADDRESS<br><b>660 KENILWORTH DRIVE 21204</b>   |  |   |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>MARCH 12, '86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN MOUNT CEMETERY BALTIMORE, MARYLAND</b> |                              |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WILLIAM E. JOHNSON 8521 LOCH RAVEN BLD.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 12 1986</b>                                   |                              |  |
| 25b. REGISTRAR'S SIGNATURE   |  |   |  |   |                              |  |

MEDICAL CERTIFICATION

912

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



NO 10022

10022

REG. NO.

FOR 4/10/86 rja  
STATE  
REGISTRAR

|   |  |  |  |  |  |  |  |   |   |  |  |                       |  |
|---|--|--|--|--|--|--|--|---|---|--|--|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>JOHN  |  | MIDDLE<br>L.   |  | LAST<br>SWOPE, JR.   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 17, 1986   |   |  |  | 2b. HOUR<br>6:45 P.M. |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 6, 1904  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |                       |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                                   |  |   |   |  |  |                       |  |
| 12. CITY OR TOWN OF DEATH<br>Towson   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Balto. Medical Center |  |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>President                   |  |   | 15. KIND OF BUSINESS OR INDUSTRY<br>Brick Mfg. Apt. 10A |  |  |                       |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br>MD   |  | 16b. COUNTY<br>BALTO.  |  | 16c. CITY OR TOWN<br>Balto.  |  | 17. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 18. STREET ADDRESS / ZIP CODE<br>4300 N. Charles St., 21218   |   |  |  |                       |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John L. Swope, Sr.  |  |  |  | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edith B. Coale  |  |  |  |   |   |  |  |                       |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>No  |  | 22. SOCIAL SECURITY NO.<br>215 01 9044   |  | 23. INFORMANT<br>ADDRESS<br>William Swope, Towson, MD 21204  |  |  |  |   |   |  |  |                       |  |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>INTRACTABLE HYPOTENSION</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>GASTROINTESTINAL BLEEDING</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>GRAM - NEGATIVE SEPSIS</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>HOURS</u><br><u>HOURS</u><br><u>4 DAYS</u> |  |  |  |  |  |  |  |   |   |  |  |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Renal FAILURE</u>  |  |  |  |  |  |  |  |   |   |  |  |                       |  |
| 25. DATE OF OPERATION<br><u>                    </u>  |  | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>                    </u>   |  |  |  | 27. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |                       |  |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 30. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>                    </u> 19 <u>                    </u>                          |  | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><u>                    </u>   |  |  |  |   |   |  |  |                       |  |
| 32. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 33. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>                    </u>                                       |  | 34. LOCATION<br>STREET <u>                    </u> CITY OR TOWN <u>                    </u> COUNTY <u>                    </u> STATE <u>                    </u> |  |  |  |   |   |  |  |                       |  |
| 35. I certify that (I) (the hospital) attended the deceased from <u>AUGUST 19 82</u> to <u>MARCH 17 86</u> , that (I) (we) last saw the deceased alive on <u>MARCH 17 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.  |  |  |  |  |  |  |  |   |   |  |  |                       |  |
| 36. SIGNATURE<br><u>John G. Lavin</u>   |  | 37. DEGREE<br>MD   |  | 38. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |  |  | 39. DATE SIGNED<br>3-18-86  |   |  |  |                       |  |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. John G. Lavin, MD   |  |  |  | 41. ADDRESS<br>6805 York Road, Balto., MD  |  |  |  |   |   |  |  |                       |  |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 43. DATE<br>3/20/86  |  | 44. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge   |  |  |  | 45. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Garrison Forest, MD  |   |  |  |                       |  |
| 46. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  |  |  | 47. DATE REC'D. BY REGISTRAR<br>MAR 19 1986  |  | 48. REGISTRAR'S SIGNATURE<br><u>John L. Jenkins</u>  |  |   |   |  |  |                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, pages 1 and 2 should be removed from this certificate. Then please remove citizen papers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

 $\frac{2}{9}$

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RESEARCH REPORT

BY

JOHN D. COLE

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy

CHICAGO, ILLINOIS

1955

THESIS

ADVISOR: DR. J. H. COLE

CO-ADVISOR: DR. J. H. COLE

CHICAGO, ILLINOIS

00-01614

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT G. TAYLOR</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 25 86</b>                  |  |  | 2b. HOUR<br><b>2:39 AM</b>   |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 30 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN)<br><b>PA</b>  |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Ba H. County</b> MD.                     |   |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hosp.</b> |   |  |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b> |   | 15. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 16a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>8 C Choate Ct. 21204</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Isaiah H. Taylor</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Dalton</b>  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b> |  | 17. INFORMANT<br>ADDRESS<br><b>Lillian Taylor - Same as #13e</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY + CARDIAC FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEVERE EMPHYSEMA + CORPULMONALE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br><b>YEARS</b> |  |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>REMOTE SUBENDOCARDIAL MYOCARDIAL INFARCTION</b>   |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3-22</b> , 19 <b>86</b> , to <b>3-25</b> , 19 <b>86</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>3/25</b> , 19 <b>86</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.       |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>JAMES W. ETHERN, JR., M.D.</b>  |  |  |   | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |   | 22c. DATE SIGNED<br><b>3/25/86</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES W. ETHERN, JR., M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>7620 YORK ROAD TOWSON MD 21204</b>  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3-29-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville, Balto. Md.</b>        |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                   |   |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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ASSISTANT ATTORNEY GENERAL

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State

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THOMAS W. CROFT, JR.



00-00672

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR XC 215 07 1551

REG. NO.

|   |  |   |   |   |  |  |
|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES C. TAYLOR</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 18 1986</b> |   | 2b. HOUR<br>M<br><b>AM</b>                                     |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCTOBER 20 1905</b>                                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>80</b>                                |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>                                 |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STEEL WORKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   | 13a. STATE<br><b>MARYLAND</b>   |  |  |
| 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James TAYLOR</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY Lou Jones</b>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>6775 WOODLEY ROAD 21222</b>                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>PEACETIME 215 07 1551</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL BLEEDING</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.              |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>OLS CVA, S/P LEFT PNEUMONECTOMY FOR CA, MASS LEFT KIDNEY, ASHD, A.F, CHF</b>   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 2</b> 19 <b>85</b> to <b>MARCH 18</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>MARCH 18</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death. |  |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Peter V. Juvan</i>   |  |   |   | 22c. DATE SIGNED<br><b>3-18-86</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER V. JUVAN, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/21/1986</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, Maryland 21222</b>                               |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1986</b>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John Duda-Ruck</i>   |  |   |   |   |  |  |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 27 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

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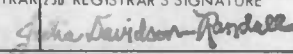


00-00110

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MILLARD TEFKE   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 5, 1986 |   |  | 2b. HOUR<br>P M<br>3:00 P M  |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 18 38   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>C. & P Towing  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Rosedale 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 31 B Oak Grove Dr. 21220  |  |   |  |   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Tefke   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Wacker  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>218-32-8048   |  | 17. INFORMANT ADDRESS<br>Geneva E. Tefke 31B Oak Grove Dr. 21220  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac pulm. arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Irregular rhythm of heart m.</u><br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/5 19 86 to 3/5 19 86 that (I) (we) last saw the deceased alive on 3/5 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>  |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>3/7/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jeffrey Quartner, M.D.  |  |   |  | 22e. ADDRESS<br>2724 N. Charles Street, Balto., 21218   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>3-8-86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Belair Memorial Gardens   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Harford County, Md.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>E.F. Lissahn F.H.  |  |   |  | 11750 Belair Rd.<br>ADDRESS<br>KINGSVILLE, MD. 21087  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 10 1986   |  | 25b. REGISTRAR'S SIGNATURE<br>           |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician (State be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REMARKS: (If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

00-90110

00-90110



070103

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07158

1- FOR  
STATE  
REGISTRAR

|   |                         |  |   |   |   |   |   |                                      |
|---|-------------------------|--|---|---|---|---|---|--------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |                         |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                                       |   |   | 2b. HOUR<br>1986  |   |                                      |
| FIRST MIDDLE LAST<br><b>ESTELLA THOMAS</b>  |                         |  | MONTH DAY YEAR<br><b>3 2 1986</b>   |   |   | 24 HOUR<br><b>6:00 PM</b>   |   |                                      |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 5 04</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>81</b> YRS.                            | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 7c. DATE<br>PRONOUNCED<br>DEAD<br><b>3 2 1986</b>                                     |   |                                      |
| 7b. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>MD</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                   |   |                                      |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Unemployed</b> |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY |
| 13a. STATE<br><b>MD</b>   |                         |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. STREET ADDRESS<br><b>21223</b><br><b>2706 W. Baltimore St</b>            |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Steven Thomas</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Johnson Thomas</b> |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>    |   |                                      |
| 16b. SOCIAL SECURITY NO.<br><b>215-50-6963</b>  |                         |  | 17. INFORMANT<br>ADDRESS<br><b>Doris Alderman 2803 Southern Ave</b>             |   |   |   |   |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MI - cardiac arrest - acute</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |                         |  |   |   |   |   |   |                                      |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |                         |  |   |   |   |   |   |                                      |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                               |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                      |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |   |                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |                                      |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |   |   |                                      |
| ACTUAL<br>SIGNATURE <b>James E. Wheeler</b>   |                         |  | TITLE (SPECIFY)<br><b>M.D.</b>  |   |   | DATE<br>SIGNED <b>3-2-86</b>  |   |                                      |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>James E. Wheeler, M.D.</b>  |                         |  | ADDRESS <b>1116 Gumbottom Rd. Crownsville 21032</b>                             |   |   |   |   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |                         |  | 23b. DATE<br><b>3/8/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cent Calvary Methodist Church</b>    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arnold MD</b>                                  |                                      |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. Marsh F.H. West 4300 Wabash Ave</b>   |                         |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1986</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. E. Wheeler</b>  |                                      |

DHMH - 17  
(VR A15 ME (5))

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))

DHMH - 17  
(VR A15 ME (5))

DHMH - 17  
(VR A15 ME (5))

DHMH - 17  
(VR A15 ME (5))

6-1-53

2 (15.50)

ONE TO NINETEEN  
PAGE NINETEEN



070036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sarah Thompson   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 4 86   |  | 2b. HOUR<br>12 <sup>40</sup> AM  |   |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 31 14   |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  |  | 8. CITIZEN OF WHAT COUNTRY?<br>United States   |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  | 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>STELLA MAE'S 2300 Rutland Ave |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>md.                          |   |
| 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 13e. STREET ADDRESS / ZIP CODE<br>1401 N. Larkwood Ave #2123   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>W. William GARRETT  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nettie Hill   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>216-28-947  |  | 17. INFORMANT<br>ADDRESS<br>Calvin Lewis 2901 Lyndhurst Ave  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from 10/29, 1985, to 3/4, 1986, that (I) (we) lost saw the deceased alive on 2/18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>K.R. Faulkner MD   |  | DEGREE  |  | 22c. DATE SIGNED<br>3/4/86   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K.R. Faulkner   |  | 22e. ADDRESS<br>Stella Marie  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>3/7/86   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie MD   |  | 24. FUNERAL DIRECTOR<br>NAME<br>Wm E. Gatta 1129 M ADDRESS<br>Caroline St.  |  |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br>MAR 7 1986  |  | 25b. REGISTRAR'S SIGNATURE<br>John W. Henderson   |  |  |   |





00-01436

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN AUTOPSY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. AFTER DEATH, THE MEDICAL EXAMINER SHOULD BE ADVISED OF THE TIME OF DEATH, THE PLACE OF DEATH, AND THE NAME OF THE FUNERAL HOME. THE MEDICAL EXAMINER SHOULD BE ADVISED OF THE TIME OF DEATH, THE PLACE OF DEATH, AND THE NAME OF THE FUNERAL HOME. THE MEDICAL EXAMINER SHOULD BE ADVISED OF THE TIME OF DEATH, THE PLACE OF DEATH, AND THE NAME OF THE FUNERAL HOME.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                 |  |  |  |  |  |   |  |                                  |  |   |  |   |  |  |  |   |  |  |  |
|--|--|-----------------|--|--|--|--|--|---|--|----------------------------------|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>GEORGE |  | MIDDLE<br>A.   |  | LAST<br>THURSBY                                |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED  |  | 2b. MONTH<br>March               |  | 2c. DAY<br>21   |  | 2d. YEAR<br>1986  |  | 2e. HOUR<br>11 <sup>15</sup>                         |  | 2f. MIN<br>M                                |  |  |  |
| 3. SEX<br>M  |  | 4. RACE<br>W    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 3, 1921   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>64 YRS |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN |  | 9. DATE<br>PRONOUNCED<br>DEAD   |  | 10. MONTH<br>March  |  | 10. DAY<br>21  |  | 10. YEAR<br>1986                            |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland   |  |                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.                                   |  |   |  |  |  |   |  |  |  |
| 11. CITY OR TOWN OF DEATH<br>TOWSON  |  |                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREATER BALTIMORE MEDICAL CENTER |  |  |  |   |  |                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Police Officer              |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>State of Md. |  |   |  |  |  |
| 13a. STATE<br>Md.  |  |                 |  | 13b. COUNTY<br>Baltimore   |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  | 13e. STREET ADDRESS<br>104 Midhurst Road 21212       |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Edward Thursby  |  |                 |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>G. Roberta Seward  |  |                                  |  |   |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |                 |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218 14 0056  |  |                                  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Lucy I. Thursby 104 Midhurst Rd. -12                           |  |   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>                 |  |                 |  |  |  |  |  |   |  |                                  |  |   |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                 |  |  |  |  |  |   |  |                                  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |                                  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                                  |  |   |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                 |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                                  |  |   |  |   |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                 |  |  |  |  |  |   |  |                                  |  |   |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><u>Charles F. O'Donnell</u>  |  |                 |  | TITLE (SPECIFY)<br><u>Medical Examiner</u>   |  |  |  | MEDICAL EXAMINER  |  |                                  |  | DATE SIGNED<br><u>3/21/86</u>   |  |   |  |  |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Charles F. O'Donnell   |  |                 |  | ADDRESS<br>7501 York Road Towson, Md. 21204  |  |  |  |   |  |                                  |  |   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                 |  | 23b. DATE<br>3/24/86   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cem.  |  |                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                    |  |   |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME, INC.  |  |                 |  |  |  |  |  |   |  |                                  |  |   |  | ADDRESS<br>6500 York Rd.  |  |  |  | 25a. DATE RECD. BY REGISTRAR<br>MAR 26 1986 |  |  |  |

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

072048

|   |  |   |   |  |                                   |
|---|--|---|---|--|-----------------------------------|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Catherine M. Tilghman</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-5-1986</b>  |   | 2b. HOUR<br><b>12:30 P</b>   |                                   |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 18 1890</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS                   |                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. Co.</b> MD.      |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Stella Maris</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>tel. operator</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                   |  |   |   |  |                                   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>BALTO.</b>   | 13c. CITY OR TOWN<br><b>BALTO.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>8303 E. Dempster Ct</b> 21234 |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Cain</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Sullivan</b>  |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>219-20-6943</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Stella Maris Records</b>            |                                   |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **ASCLVD**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Abdominal Tumor - UNKNOWN TYPE**

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-15</b> , 19 <b>82</b> , to <b>3-5</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3-5</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Dr. Faulkner</b>  |  |  |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |   |

|   |                            |   |  |
|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>3/7/86</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Cockeysville Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld</b>     |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1986</b>         | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be advised of this.

## MEDICAL CERTIFICATION

| Film G615 item 6   |  |  |  |  |   |  |  |  |                                      | STATE OF MARYLAND  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--------------------------------------|--|--|-----------------------------|--|--|---|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE 5/1/86 rja REGISTRAR  |  |  |  |  |   |  |  |  |                                      | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  |   |  |  |  |                                      | 2a. DATE OF DEATH MONTH DAY YEAR   |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Mrs. Sabina Tokman   |  |  |  |  |   |  |  |  |                                      | March 31 1986  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |   | 5. DATE OF BIRTH MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  | IF UNDER 24 HRS. HOURS MIN.   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Female   |  |  | Caucasian  |  |   | December 28 1919   |  |  | 65 66 YRS.                           |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Russia   |  |  | United States  |  |   |  |  |  | Baltimore County                     |  |  |                             |  |  | MD  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Pikesville   |  |  | 3922 N. Rolling Road Apt. 5A   |  |   | Cook-Rabbinical  |  |  | School                               |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |   |  |  |  |                                      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  |   | 13c. CITY OR TOWN  |  |  | 13e. STREET ADDRESS / ZIP CODE       |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  | Baltimore  |  |   | Pikesville   |  |  | 3922 N. Rolling Road                 |  |  | 21208                       |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                          |  |  |  |                                      |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Wilhelm Daszkewicz   |  |  |  |  | Maria Tatur   |  |  |  |                                      |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)                |  |  |  |                                      | 17. HOME ADDRESS   |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| no   |  |  |  |  | 214-66-5728   |  |  |  |                                      | 3922 N. Rolling Road Pikesville Maryland   |  |                             |  |  | 21208   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u>  |  |  |  |  |   |  |  |  |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>                                    |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>   |  |  |  |  |   |  |  |  |                                      |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>  |  |  |  |  |   |  |  |  |                                      |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u>   |  |  |  |  |   |  |  |  |                                      |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  |                                      | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |                             |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  |  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)              |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  |                                      | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/12/85</u> , 19 <u>85</u> , to <u>3/31</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |                                      |  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>Boris Kerkner, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |  |   |  |  |  |                                      | 22c. DATE SIGNED <u>4/1/86</u>   |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Boris Kerkner, M.D.</u>   |  |  |  |  |   |  |  |  |                                      | 22e. ADDRESS <u>131 Slade Avenue</u>   |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  | 23b. DATE   |  |  |  |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |  |                             |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  | 4-02-86   |  |  |  |                                      | Druid Ridge Cemetery   |  |                             |  |  | Pikesville Baltimore Maryland   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <u>Loring Byers Funeral Directors, Inc.</u> NAME ADDRESS  |  |  |  |  |   |  |  |  |                                      | 25a. DATE REC'D. BY REGISTRAR  |  |                             |  |  |   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |  |  |  |  |
| 8728 Liberty Road Randallstown, Maryland 21133   |  |  |  |  |   |  |  |  |                                      | APR 07 1986  |  |                             |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |

BP

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2003 OCT 20

11/11/03



TO: George Washington, Virginia 22203  
FROM: [illegible]  
SUBJECT: [illegible]

00-00108

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>REBECCA E. TRASKEY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>9</b> YEAR <b>86</b> |  |  | 2b. HOUR<br><b>11<sup>30</sup> P.M.</b>  |  |  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>18</b> YEAR <b>13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | 8. IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson, MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>                             |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |  |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Towson</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>153 Versailles Circle 21204</b>                                 |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Hiteshew</b> LAST <b>Staley</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ann</b> MIDDLE <b>Staley</b> LAST <b>Staley</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>578-44-7309</b>  |  | 17. INFORMANT<br>ADDRESS <b>21204</b><br><b>Ann T. Jones -1003 Malvern Ct., Towson, Md.</b>                      |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>OVARIAN CARCINOMA</b>   |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 MOS.</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |   |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>RENAL FAILURE</b>   |  |  |   |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR <b>A.M.</b> MONTH <b>16</b> DAY <b>19</b> YEAR <b>86</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET <b>7600 OSLER DRIVE</b> CITY OR TOWN <b>TOWSON</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b> |  |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>2-16-86</b> to <b>3-9-86</b> that (1) (we) lost<br>saw the deceased alive on <b>3-9-86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>J. KLEEMAN</b>   |  |  |   | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>3-10-86</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. KLEEMAN</b>  |  |  |   | 22e. ADDRESS<br><b>7600 OSLER DRIVE TOWSON</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |   | 23b. DATE<br><b>3-12-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Cockeysville, Balto., Md.</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>1050 York Rd.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1986</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21204

BP  
DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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064048

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br>Marguerite Ebba Maria Travers   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>March 1, 1986   |  | 2b HOUR<br>6 am   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Oct. 16, 1902  |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br>83  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County   |  |
| 10 CITY OR TOWN OF DEATH<br>Pikesville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN BALTIMORE CITY, GIVE STREET ADDRESS)<br>804 Olmstead Rd. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.   |  | 13b COUNTY<br>Balto.   |  | 13c CITY OR TOWN<br>Pikesville   |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Carl E. Ringquist  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna C. Arner  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b SOCIAL SECURITY NO.<br>217-03-7935  |  |
| 17 INFORMANT<br>ADDRESS<br>804 Olmstead Rd.,<br>F. Arnold Travers Pikesville, Md. 21208   |  |  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Sideroblastic anemia.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><i>Irvin Hyatt M.D.</i>  |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c DATE SIGNED<br>3/3/86   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>IRVIN HYATT M.D.  |  | 22e ADDRESS<br>19 Walker Ave - 21208 -   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>Mar. 4, 1986   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Balto., Md.  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>H. E. Ehlhardt</i>  |  | ADDRESS<br>Owings Mills, Md. 21117   |  | 25a DATE REC'D. BY REGISTRAR<br>MAR 3 1986   |  | 25b REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |

MEDICAL CERTIFICATION

BP \_\_\_\_\_

DHMH - 16 60M 7/B4  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is notified of this.

March 1, 1968

John Edgar Hoover

March 1, 1968

Director, FBI

Dear Sir:

Enclosed

For: Bureau of Prisons

100-442112

100-442112

100-442112

Very truly yours,

Director

cc

The Bureau of Prisons, Washington, D.C.

100-442112

100-442112

100-442112



Enclosure

100-442112

100-442112

100-442112

00-01626

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 07165

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |   |  |   |   |  |
|--|--|--|---|--|---|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mrs. Ada M. Trent</b>   |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 26 1986</b>            |  |   | 2b HOUR<br><b>18:30 M</b>  |   |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Caucasian</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 1 1908</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Texas</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>L. P. N.</b>             |   | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Baltimore</b>   |   | 13c CITY OR TOWN<br><b>Balto. County</b>   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS / ZIP CODE<br><b>104 Village of Pine Court 21207</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Isaac Trent</b>  |  |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Laura Hurley</b>  |   |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>415-38-2652</b>   |   | 17 INFORMANT<br><b>Mrs. Dolores A. Morrow</b>  |   | ADDRESS<br><b>104 Village of Pine Ct., Baltimore</b>   |   | 21207<br><b>Maryland</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident Secondary</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>to Hypertensive Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chr. Renal failure</b> |  |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |  |   |  |   |   |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>3-21</b> , 19 <b>86</b> , to <b>3-26</b> , 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>3-26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (I did) (I did not) view the body after death.  |  |  |   |  |   |  |   |   |  |
| 22b SIGNATURE<br><b>Govinda R. Govinda</b>   |  |  |   | DEGREE<br><b>MD</b>  |   |  |   | 22c DATE SIGNED<br><b>3-26-86</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GOVINDA R. GOVINDA</b>  |  |  |   | 22e ADDRESS<br><b>BALTIMORE COUNTY GENL Hospital</b>   |   |  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b DATE<br><b>03-29-86</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b> |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Maryland</b> |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |  |  |   |  | 25a DATE REC'D. BY REGISTRAR<br><b>MAR 31 1986</b>                  |  | 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                      |   |  |
| 8728 Liberty Road Randallstown, Maryland 21133   |  |  |   |  |   |  |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. Name: [illegible]  
 2. Address: [illegible]  
 3. City: [illegible]  
 4. State: [illegible]  
 5. Zip: [illegible]  
 6. Date: [illegible]  
 7. Signature: [illegible]  
 8. Title: [illegible]  
 9. Organization: [illegible]  
 10. Purpose: [illegible]

11. Name: [illegible]  
 12. Address: [illegible]  
 13. City: [illegible]  
 14. State: [illegible]  
 15. Zip: [illegible]  
 16. Date: [illegible]  
 17. Signature: [illegible]  
 18. Title: [illegible]  
 19. Organization: [illegible]  
 20. Purpose: [illegible]

066061

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 6

07166

 1- FOR  
 STATE  
 REGISTRAR

REG. NO.

|   |  |   |  |  |                                    |  |                               |   |              |   |  |
|---|--|---|--|--|------------------------------------|--|-------------------------------|---|--------------|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST  |  |                                    | 2a DATE OF DEATH MONTH DAY YEAR  |                               |   |              | 2b HOUR   |  |
| JOANNA  |  |   | S. TRIESCHMAN  |  |                                    | March 4, 1986  |                               |   |              | 7:50A M   |  |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |                                    | 6 AGE (IN YEARS LAST BIRTHDAY)   |                               | IF UNDER 1 YEAR<br>MONTHS DAYS  |              | IF UNDER 24 HRS<br>HOURS MIN.                                       |  |
| Female  |  | White   |  | September 17, 1896   |                                    | 89 YRS   |                               |   |              |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH  |                               |   |              |   |  |
| Maryland  |  | U.S.A.  |  |  |                                    | Baltimore County MD.   |                               |   |              |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                    | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                |                               | 12b. KIND OF BUSINESS OR INDUSTRY   |              |   |  |
| Catonsville   |  | Summit Nursing Home   |  |  |                                    | Housewife  |                               | Own Home  |              |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |                                    | 13b CITY OR TOWN   |                               | 13c INSIDE CITY LIMITS?   |              | 13d STREET ADDRESS / ZIP CODE                                       |  |
| Maryland  |  |   |  |  |                                    | --   |                               | Baltimore   |              | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  |  |                                    | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                   |                               |   |              |   |  |
| Howard Saffell  |  |   |  |  |                                    | Emma E. Maxwell  |                               |   |              |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                 |  |                                    | 17 INFORMANT<br>ADDRESS  |                               |   |              |   |  |
| No  |  |   | 213-74-5848  |  |                                    | William E. Trieschman Jr. 1226 Pleasant Valley Dr. Baltimore, MD. 21228        |                               |   |              |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |  |  |                                    |  |                               |   |              | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>   |  |   |  |  |                                    |  |                               |   |              |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Septecemia</u>   |  |   |  |  |                                    |  |                               |   |              |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |   |  |  |                                    |  |                               |   |              |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Cardio Vascular Disease</u>   |  |   |  |  |                                    |  |                               |   |              |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>   |  |   |  |  |                                    |  |                               |   |              |   |  |
| 19a DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    | 20a AUTOPSY?   |                               | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |              |   |  |
|   |  |   |  |  |                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                               | YES <input type="checkbox"/> NO <input type="checkbox"/>  |              |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR                        |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                               |   |              |   |  |
|   |  |   | P.M. 19  |  |                                    |  |                               |   |              |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET  |                               | CITY OR TOWN  |              | COUNTY STATE  |  |
|   |  |   |  |  |                                    |  |                               |   |              |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>June 24,</u> 19 <u>85</u> to <u>March 4,</u> 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>March 3,</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                                    |  |                               |   |              |   |  |
| 22b SIGNATURE<br><u>James E. Rowe</u>   |  |   |  |  |                                    | DEGREE<br><u>MD</u>  |                               | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |              | 22c. DATE SIGNED<br><u>March 4, 1986</u>                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |  |                                    | 22e. ADDRESS   |                               |   |              |   |  |
| James E. Rowe M.D.  |  |   |  |  |                                    | 413 Commonwealth Avenue, Baltimore, MD.  |                               |   |              |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN |   | COUNTY STATE |   |  |
| Burial  |  |   | 3/7/86   |  | Baltimore National                 |  | Baltimore                     |   | Maryland     |   |  |
| 24. FUNERAL DIRECTOR<br><u>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</u><br><u>1630 Edmondson Avenue, Catonsville, MD. 21228</u>  |  |   |  |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |                               | 25b. REGISTRAR'S SIGNATURE  |              |   |  |
|   |  |   |  |  |                                    | MAR 5 1986   |                               | <u>Julia Davidson-Randall</u>   |              |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100

100-100

100-100

100-100



10-01466

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07167

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA MARIE TRIPLETT</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MARCH 21-86</b> |   |   | 2b. HOUR<br><b>1:30</b> P.M.   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>JAN 19 1898</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>625 COLERAINE RD</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MANAGER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RESTAURANT</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>MD</b> 13c. COUNTY <b>BALTO</b> 13d. CITY OR TOWN <b>CATONSVILLE</b> |  |  |  |   | 13e. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13f. STREET ADDRESS / ZIP CODE<br><b>625 COLERAINE RD. 21229</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>THOMAS J. TRIPLETT</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>ABBYGAIL GREENE</b>  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-01-0516</b>  |  | 17. INFORMANT<br>ADDRESS <b>617 WILLIAM RIGHTOR LAKESHORE DR</b>  |   |  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8:17 P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/17</b> 19 <b>84</b> , to <b>11/29</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>3/24/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>1100 MAIDEN CHOICE LANE</b>  |  |  |  | 22e. ADDRESS   |  |   |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>CITY <b>BURIAL</b>                                |  | 23b. DATE<br><b>3/24/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WEBER FUNERAL HOME EDMONDSON AVE 5311</b> |  |                             |  | 25a. DATE REC'D BY REGISTRAR<br><b>MAR 26 1986</b>         |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0-0166

MARCH 21-24 1988

MARIE TRIPLET

ANNA

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MAY 19 1988

W

F

BALTO COUNTY

USA

MARYLAND

MANAGED RESTAURANT

635 COLUMBIA RD

CATONSVILLE

635 COLUMBIA RD

BALTO CATONSVILLE

MD

GREEN  
WILLIAM KNOTT PARKWAY  
BALTO

3/24/88 LORRAINE PARK

BURIAL

BALTO MD

WEBER FERNALD HOME EMBROIDERY AVE

8311



070078

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 6 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Clifton A Uebel</i>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3 6 86</i>   |  | 2b. HOUR<br>M<br><i>M</i>   |
| 3. SEX<br><i>Male</i>  | 4 RACE<br><i>Caucasian</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9 15 08</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>77</i>                            |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                                    |   |
| 10. CITY OR TOWN OF DEATH<br><i>Randallstown</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore County General Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Gas Station Attendant</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |   |   | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>August Uebel</i>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Louise Deitz</i>                             |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>217-03-0151</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Mr. Edward Uebel</i><br><i>2825 Ridge Rd. Baltimore, Maryland 21207</i> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Ventricular tachycardia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 23, 1984</i> to <i>March 6, 1986</i> , that (I) (we) last saw the deceased alive on <i>Feb. 13, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |   |   |  |  |   |
| 22b. SIGNATURE<br><i>Jerome H. Ginsberg M.D.</i>   |   | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br><i>3-7-86</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Jerome H. Ginsberg, M. D.</i>  |   | 22e. ADDRESS<br><i>8630 Liberty Plaza Mall<br/>Randallstown, Maryland 21133</i>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |   | 23b. DATE<br><i>3/8/86</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mount Olive Cemetery</i>                                      |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Randallstown Baltimore MD</i>   |   | 23e. DATE REC'D. BY REGISTRAR<br><i>MAR 7 1986</i>  |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Loring Byers Funeral Directors, Inc.</i>  |   | ADDRESS<br><i>8728 Liberty Rd. Randallstown, MD. 21133</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RECEIVED  
JAN 10 1962  
RECEIVED



00-01642

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 6 0 7 1 6 9  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |
|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harry Oscar UHLER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 23, 1986</b>                             |   | 2b. HOUR<br><b>11:30 PM</b>                              |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 31 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randalltown</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. County Gen Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>self employed</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Oil Business</b> |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>12 Hawthorne Av, 21208</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Uhler</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Molly Benson</b>   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No --</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-32-776</b>  |  | 17. INFORMANT <b>Pikesville</b> ADDRESS <b>MD 21208</b><br><b>Mrs. Maud Fox Uhler 12 Hawthorne Ave.</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Respiratory failure -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Left lower lobe pneumonia -</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 days</b> |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>COPD -</b>  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>03/24/86</b> , 19 <b>86</b> , to <b>03/24/86</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>03/24/86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Suresh Gupta</b>   |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>03/24/86</b>                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURESH K Gupta</b>  |  | 22e. ADDRESS<br><b>Balto Co Gen Hospital Balto Md</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3-26-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Baltimore MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc<br/>8728 Liberty Rd. Randallstown, MD 21133</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 27 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Gelia Davidson-Randall</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-61085



MAK 11 1988

00-01464

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CARROLL</b>   |  | FIRST MIDDLE LAST<br><b>VAN NESS Jr.</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>3 20 86</b>  |  | 2b. HOUR<br><b>10:55p.m.</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 4, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>General</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Owings Mills</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Carroll</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosalie Porter</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>10809 Hudson Rd., 21117</b>  |  | Motors  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>                                       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213 10 4106</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Helen Van Ness,</b>   |  | Same  |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CORONARY ATHEROSCLEROSIS</b><br><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|  |  |
|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>BENIGN PROSTATIC HYPERTROPHY</b> |  |
|--|--|

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |

|   |  |
|---|--|
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/17 19-86</b> to <b>3/20 19-86</b> that (I) (we) last saw the deceased alive on <b>3/20 19-86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
|---|--|

|  |  |  |  |                                    |  |
|--|--|--|--|------------------------------------|--|
| 22b. SIGNATURE<br><i>Joel Hammer</i>                                 |  | DEGREE<br><i>MD</i>                              |  | 22c. DATE SIGNED<br><b>3/21/86</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOEL L. HAMMER, M.D.</b> |  | 22e. ADDRESS<br><b>6701 N. CHARLES ST. 21204</b> |  |                                    |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b> |  | 23b. DATE<br><b>3/22/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b> |  |
|---|--|-----------------------------|--|--|--|---|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 24 1986</b> |  | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i> |  |
| 4905 York Road Balto., MD 21212  |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked, or item 8 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

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Creation

Henry W. Johnston & Son Co.

4005 York Road, Suite 200, York, PA 17403

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 7 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Minnie Emma Varner</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 27, 1986</b>               |   |  | 2b. HOUR<br><b>8:55 AM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 19 1902</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>83</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Heritage Meridian Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>3004 Dunleer Rd./ Balto., Md 21222</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Stem</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ivy Miller</b>     |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>               |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>216/46/2277</b>  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Balto., Md.</b>                         |   |  | 17. INFORMANT<br>ADDRESS<br><b>Virginia L. Riley 2967 Liberty Pkwy. 21222</b>                   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSELENOTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4 YEARS</b>  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 DAY</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9 P.M. 19</b>    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/30</b> 19 <b>82</b> to <b>3/27</b> 19 <b>86</b> , that (I) (we) lost<br>saw the deceased alive on <b>3/27</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) see the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>B. C. VENERATION JR</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>3/27/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. C. VENERATION JR</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>3401 DUNDALK BALTO 21222</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>3/29/1986</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland 21224</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Brooks Bradley Inc. Balto., Md. 21222</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 01 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. Davidson-Randell</b>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10050-001

RECEIVED 100%

UNITED STATES





00-02041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |  |  |  |  |   |  |
|--|--|---|---|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>SIDNEY JOHNSON VENABLE   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 18, 1986                  |  |  | 2b HOUR<br>3:10 P.M.   |  |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 13, 1894   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>91<br>YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Arkansas  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>610 Wilton Rd. |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clergyman                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Religious   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Delaware   |  |   |   | 13b CITY OR TOWN<br>Wilmington   |  | 13c INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d STREET ADDRESS / ZIP CODE<br>508 Marsh Rd. 19809  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Sidney Venable   |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sallie Garden  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |   | 16b SOCIAL SECURITY NO.<br>212-36-5907   |  | 17 INFORMANT<br>ADDRESS 610 Wilton Rd.<br>Dr. Sidney J. Venable, Jr. Towson, Md. 21204         |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic Cardiovascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MIN<br>48 hrs   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Arteriosclerotic Cardiovascular Disease</u>   |  |   |   |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a I certify that (I) (the hospital) attended the deceased from <u>NOV 81</u> 19 <u>81</u> to <u>MAR 18</u> 19 <u>86</u> that (I) (we) lost saw the deceased alive on <u>MAR 18</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |   |  |  |  |  |   |  |
| 22b SIGNATURE<br><u>S. J. Venable Jr M.D.</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |   |  |  | 22c DATE SIGNED<br>3-19-86   |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. J. VENABLE JR M.D.  |  |   |   |  |  | 22e ADDRESS<br>7215 YORK RD BALTIMORE MD. 21212  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b DATE<br>Mar. 21, 1986   |  | 23c NAME OF CEMETERY OR CREMATORY<br>West Nottingham |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Colora, Cecil Co., Maryland |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212   |  |   |   |  |  | 25 DATE REC'D BY REGISTRAR<br>MAR 26 1986  |  | 25b REGISTRAR'S SIGNATURE   |  |

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "SINGAPORE" and "MAY" are visible.]*

00-200057

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUIS O. VLACH</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>'86</b>      |  |   | 2b. HOUR<br><b>12:59a<sub>M</sub></b>  |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH<br><b>M10 14 '26</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N.CHARLES ST.</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROJECT ENGINEER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UTILITY</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |   |  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>21234</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7912 DALESFORD ROAD 21234</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>MICHAEL</b> MIDDLE LAST <b>VLACH</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>KATHERINE</b> MIDDLE LAST <b>RUNGE</b>           |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. II 219-22-6440</b> |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. HELEN G. VLACH BALTIMORE, MD21234</b>        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF THE URINARY BLADDER</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b> |  |   |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> 19 <b>86</b> to <b>3/11</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/11</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Craig M. Shaughnessy</i>  |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/11/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CRAIG M. SHAUGHNESSY, M.D.</b>   |  |   |  |  |   | 22e. ADDRESS<br><b>GBMC-6701 N.CHARLES ST.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SEE #1)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>MARCH 14, '86</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEM. PARK</b>                       |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE CO.,</b> COUNTY <b>MARYLAND</b> STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>  |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 12 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>William E. Johnson</i>  |  |
| ADDRESS<br><b>8521 LOCH RAVEN BLVD.</b>  |  |   |  |  |   |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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071159

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |                  |   |   |   |                     |
|---|------------------|---|---|---|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>BARBARA ANN VOTTA |                  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 8 1986 |   | 2b. HOUR<br>4:30P M |
| 3. SEX<br>Female  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 4 1950  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>35 YRS   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                         |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                          |                     |
| 10. CITY OR TOWN OF DEATH<br>Woodlawn   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1529 Barrett Rd. Woodlawn, Md. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electronic Packer |                     |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Woodlawn   |                     |
| 14. FATHER'S NAME<br>Anthony Michael Votta                                    |                  | 15. MOTHER'S MAIDEN NAME<br>Theresa Constance Ginski  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Westinghouse                                     |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO    |                  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>214-62-3613  |   | 17. INFORMANT<br>ADDRESS<br>Anthony Votta SAME AS 13c.                                |                     |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
10 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 30, 1993, to March 8, 1996, that (I) (we) last saw the deceased alive on Jan 27, 1996, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |

|   |        |  |                             |
|---|--------|--|-----------------------------|
| 21g. SIGNATURE<br>Russell R. Deluca M.D.                        | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>3/10/96 |
| 21h. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Russell R. Deluca M.D. |        | 22e. ADDRESS<br>University of Maryland Hospital, Baltimore, MD.  |                             |

|   |                      |  |   |
|---|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial                       | 23b. DATE<br>3/12/86 | 23c. NAME OF CEMETERY OR CREMATORY<br>Crestlawn Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Marriottsville Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy M. & Russell C. Witzke Funeral Home |                      | 25a. DATE REC'D. BY REGISTRAR<br>MAR 10 1986             | 25b. REGISTRAR'S SIGNATURE<br>John A. Anderson                        |

MEDICAL CERTIFICATION

279

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

011170

100% COTTON FIBER

100% COTTON FIBER



00-018621-

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

07175

REG. NO.

|  |   |   |   |                       |   |       |                                    |      |                  |
|--|---|---|---|-----------------------|---|-------|------------------------------------|------|------------------|
| 1. DECEASED NAME<br>(Type or Print)                                  |   | FIRST   | MIDDLE  | LAST                  | 2a. DATE OF DEATH   | MONTH | DAY                                | YEAR | 2b. HOUR         |
| ELIZABETH  |   |   | D.  | WAGNER                | 3   | 21    | 86                                 |      | 10:30 AM         |
| 3. SEX   | 4. RACE   |   | 5. DATE OF BIRTH  |                       | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |       | IF UNDER 1 YEAR                    |      | IF UNDER 24 HRS. |
| FEMALE   | WHITE   |   | OCT. 9 1889   |                       | 97  |       | MONTHS DAYS                        |      | HOURS MIN.       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                            | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |       |                                    |      |                  |
| MARYLAND   | U.S.A.  |   |   |                       | BALTO. CO.  |       |                                    |      |                  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |                       | 12b. KIND OF BUSINESS OR INDUSTRY                                   |       |                                    |      |                  |
| BALTO.   | BALTO. CO. GENERAL HOSPT.   |   | FACTORY WORKER  |                       |   |       |                                    |      |                  |
| 13a. STATE   | 13b. COUNTY   |   | 13c. CITY OR TOWN   |                       | 13d. INSIDE CITY LIMITS?  |       | 13e. STREET ADDRESS / ZIP CODE     |      |                  |
| MD   | BALTO. CO.  |   | BALTO.  |                       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       | 1634 E. 32 <sup>ND</sup> ST. 21218 |      |                  |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME                                |   |                       |   |       |                                    |      |                  |
| FIRST MIDDLE LAST  |   | FIRST MIDDLE LAST                                       |   |                       |   |       |                                    |      |                  |
| VOLLEERTHUM  |   | HENRIETTA   |   | DIETRICK              |   |       |                                    |      |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |   | 17. INFORMANT ADDRESS |   |       |                                    |      |                  |
| NO   |   | 212-32-3469   |   | FAMILY RECORDS        |   |       |                                    |      |                  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3.20, 19 86, to 3.21, 19 86, that (I) (we) last saw the deceased alive on 3.21, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (had) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| RAYADURG GOVINDA RAO MD  |  | MD  |  |  |  | 3.21.86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |   |  |
| RAYADURG GOVINDA RAO MD  |  | BALTIMORE COUNTY GENL Hospital.                                   |  |  |  |   |  |

|   |  |              |  |                                    |  |  |  |
|---|--|--------------|--|------------------------------------|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)      |  | 23b. DATE    |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| CREMATION   |  | MARCH 24, 86 |  | GREENMOUNT CEM.                    |  | BALTO. CITY MD                             |  |
| 24. FUNERAL DIRECTOR<br>NAME                      |  |              |  | 25a. DATE REC'D. BY REGISTRAR      |  | 25b. REGISTRAR'S SIGNATURE                 |  |
| EVANS CHAPEL OF CHIMES 2325 YORK RD TIMOTHY M, MD |  |              |  | MAR 27 1986                        |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1-3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED  
JAN 11 1964  
FBI  
NEW YORK



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072046

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 7 6

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William Robert Ward  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 7 1986               |   |  | 2b. HOUR<br>7:13A M   |  |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 24 1903   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3006 Dunmurry Rd./ 21222 |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self Employed   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Service Station  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS / ZIP CODE<br>3006 Dunmurry Rd./21222   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Ward  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hannah Cutty |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213/09/2046  |   | 17. INFORMANT<br>ADDRESS<br>Cynthia E. Ward (wife-sameas 13e.)  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>NEPHROTIC CA PROSTATE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>5 YRS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0   |  |   |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-24-19 to 3-6-19 (not (I, we) lost sight of the deceased alive or above (I, we) did not view the body after death)  |  |   |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Dr. Harvey N. Schonwald MD  |  |   |   | 22c. DATE SIGNED<br>3-7-86  |  |   |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Harvey N. Schonwald  |  |   |   | 22f. ADDRESS<br>660 Kenilworth Drive Towson, Md. 21204  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>3/10/1986  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Brooks Bradley Inc. Balto., Md. 21222  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 11 1986  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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CHIEFLY POWD

100% cotton HDEB

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1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Jennie Belle WARE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>March 11, 1986</b>                          |  | 2b. HOUR<br><b>12:55<sup>p</sup></b>                    |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>February 14, 1911</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75 YRS.</b>                              |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>            |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Garment Co.</b> |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Essex</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Wood</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah E. Newman</b>               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>422 01 0342</b>  |   | 17. INFORMANT ADDRESS<br><b>21221 Sarah Lepus 34 Riverside Rd. Balto., Md.</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac asystole, Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Opening in viscus causing pneumoperitoneum</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>  |  |   |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 1, 1986</b> to <b>March 11, 1986</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>March 11, 1986</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>John D. Merwin</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John D. Merwin, M.D.</b>  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>3/14/86</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                 |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |  |   |   |  |   |
| 24. FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 13 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Pondell</b>                     |   |

MEDICAL CERTIFICATION

9-9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return all pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.  
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

[illegible]

069029

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALICE JANE FERRIER WARRINER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>05</b> YEAR <b>'86</b>     |   |  | 2b. HOUR<br><b>8:30A</b> M  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Sept.</b> DAY <b>15</b> YEAR <b>1919</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>CA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> MD.                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Ruxton</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1015 Wagner Road, 21204</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Paul</b> MIDDLE <b>Alexander</b> LAST <b>Ferrier</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Genevieve</b> MIDDLE <b></b> LAST <b>Stevenson</b>  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>224 48 2991</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Mercer Warriner, Same</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>DILATED CARDIOMYOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHF</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>86</b> , to <b>3/5</b> , 19 <b>86</b> , that (I) (we) saw the deceased alive on <b>3/5</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Raymond Nze</i>  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>3/5/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAYMOND NZE, M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>GBMC - 6701 N. CHARLES STREET 21204</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>3/6/86</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto.,</b> COUNTY <b>MD</b> STATE                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., MD 21212</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, the funeral director should file the certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, state any injury, accident, traumatic event, the medical examiner must be notified on page 4.

observed

00-0218

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07179

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 7b. HOUR   |  |
| EIHANA E. WASHINGTON JR.   |  |  |  | 3-29-86   |  |  |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                          |  | IF UNDER 1 YEAR  |  |
| MALE   |  | BLACK  |  | 9/19/25   |  | 60 YRS   |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |  |  |
| MD   |  | U.S.A.   |  |   |  | BALTIMORE COUNTY MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. SECOND BUSINESS OR INDUSTRY                         |  |  |  |
| BALTIMORE  |  | ST Joseph Hospital   |  | CHAUFFEUR   |  | U.S. GOVERNMENT-CIA                                      |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS / ZIP CODE                                 |  |
| MARYLAND   |  |  |  |   |  | BALTIMORE  |  | 342 MELVIN AVE. BALTIMORE, MD, 21228                           |  |
| FATHER'S NAME  |  | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME                                 |  | FIRST MIDDLE LAST  |  |
| ELHANA   |  | EDWARD   |  | WASHINGTON  |  | EDNA   |  | HARDY  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |  |  |
| YES  |  | WW II  |  | 215-22-8015   |  | KATHLEEN FRANCE  |  | 412 N. LOUDON AVE. BALTIMORE, MD, 21229                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST   |  |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC COLONIC CARCINOMA  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/29, 19 86, to 3/29, 19 86, that (I) (we) lost saw the deceased alive on 3/29, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED   |  |
| Edward Wolf  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  | 5/29   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |
| Edward Wolf  |  |  |  | St. Joseph Hospital   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  | COUNTY STATE   |  |
| BURIAL   |  | 4/4/86   |  | GARRISON FOREST VETERANS  |  | BALTIMORE  |  | BALTIMORE, MARYLAND  |  |
| 24. FUNERAL HOME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                               |  |  |  |
| 2501 GWYNNS FALLS PKWY, BALTO, MD, 21216   |  |  |  | APR 02 1986   |  | [Signature]  |  |  |  |



00-05181

Page 2.11

SH

(1)



00-01078

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

07180

REG. NO.

|   |  |  |  |  |   |   |   |   |   |   |  |
|---|--|--|--|--|---|---|---|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARIA E WATERS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>03 18 86</b>                 |  |   | 2b. HOUR<br>M<br><b>M</b>   |   |   |   |   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>BLACK</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 26 26</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>59</b>                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                      |   |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEKEEPING</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>PHOENIX</b>                                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3001 PAPER MILL RD PHOENIX 21131</b> |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence E. Waters</b>  |  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine C. Beale</b> |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE DATE)<br><b>n/a</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>21131</b>  |   | Catherine Waters 3001 PaperMill Rd  |   |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute MYOCARDIAL INFARCTION</b>   |  |  |  |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 hour</b>          |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |   |   |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>HYPERTENSION, BRONCHIAL ASTHMA</b>  |  |  |  |  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3/18 86</b>      |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)          |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/18 86</b> to <b>SAME</b> 19 <b>86</b> that (I) (we) last saw the deceased alive on <b>3/5 86</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Mark S. Kaplan MD</b>  |  |  |  |  |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK S. KAPLAN MD</b>   |  |  |  |  |   | 22e. ADDRESS<br><b>16918 YORK RD. MONKTON MD</b>  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>3/22/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md. 21111</b>                           |   |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Leroy O. Dyett</b>  |  |  |  |  |   | ADDRESS<br><b>4600 Lib. Hgts. Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 21 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. H. Anderson-Randall</b> |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-01173

BALTIMORE COUNTY

HOUSEKEEPING

JOHN BAKER WILL BE PROMOTED



00-00670

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine.

|   |  |   |  |  |   |   |   |  |  |                                    |  |
|---|--|---|--|--|---|---|---|--|--|------------------------------------|--|
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |   |   |   |  |  | 8 6 0 7 1 8 1                      |  |
| 1- FOR STATE REGISTRAR  |  | REG. NO.  |  |  |   |   |   |  |  |                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>(The Honorable) R. Dorsey Watkins</b>  |  |   |  |  | 2a. DATE OF DEATH<br><b>March 19, 1986</b>  |   |   | 2b. HOUR<br><b>2:00 A.M.</b>               |  |                                    |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Sept. 27, 1900-85</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85 YRS.</b>                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS          |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>                 |   |  |  |                                    |  |
| 12. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11 S. Belle Grove Road</b> |  |  |   | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>District Judge</b> |   |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Fed. Court</b>  |                                    |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b>  |  |   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>11 S. Belle Grove Road 21228</b>     |  |  |                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Marion Watkins</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Harriett Isabelle Strong</b>  |   |   |  |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-30-2756</b>  |  | 17. INFORMANT<br><b>Baltimore, Md. 21201.</b><br><b>Ms. Rose M. Jackson-320 U.S. Court House</b>   |   |   |   |  |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of soft palate</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |   |   |   |  |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |  |   |   |   |  |  |                                    |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/29, 1983</b> to <b>3/18, 1986</b> , that (I) (we) saw the deceased alive on <b>3, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |  |   |   |   |  |  |                                    |  |
| 22b. SIGNATURE<br><b>John W. Bowie, M.D.</b>  |  |   |  |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  |  | 22d. DATE SIGNED<br><b>3/18/86</b> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John W. Bowie, M. D.</b>  |  |   |  |  | 22f. ADDRESS<br><b>Baltimore, Md.<br/>500 West University Parkway - 21218</b>   |   |   |  |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>3/22/86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Orleans Cemetery - East Orleans, Cape Cod, Mass.</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |                                    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Sterling Funeral Estate, P.A.<br/>736 Edmondson Ave.; Catonsville, Md. 21228</b>   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 19 1986</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>               |  |  |                                    |  |

March 1, 1963

March 1, 1963

March 1, 1963

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March 1, 1963

March 1, 1963

March 1, 1963

00-01449

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                         |  |   |  |  |
|---|-------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WALTER</b>   |                         | 2a. DATE KNOWN<br>OF ESTI-<br>MATED <b>19</b>  |   | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 28 1912</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY - YRS. <b>73</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE<br>PRONOUNCED<br>DEAD <b>MAR 25 19 86</b> |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>Baltimore Md.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville 21237</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sq. Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Cable Handler</b> |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. CITY OR TOWN<br><b>Baltimore</b>  |   | 13c. STREET ADDRESS<br><b>218 Kingston Rd. 21220</b>                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ralph Weaver</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Gesswein</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>216 03 0346</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Harry Zulauf, Stepson Same</b>                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIO-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>VASCULAR DISEASE</b><br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c)  |                         |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                         |  |   |  |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that I took charge of the deceased described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |  |  |
| ACTUAL<br>SIGNATURE <b>Paul F. Guerin</b>   |                         | TITLE (SPECIFY)<br><b>DEPUTY</b>   |   | DATE<br>SIGNED <b>3/25/86</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>PAUL F. GUERIN</b>  |                         | ADDRESS <b>1201 KRUGER AVE<br/>BALTIMORE MD 21237</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |                         | 23b. DATE<br><b>3/28/86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home PA 1407 Old Eastern Ave 21221</b>  |                         |  |   |  |  |

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

100% COTTON

100% COTTON

00-01243

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |         |  |  |   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
|--|---------|--|--|---|--|--|--|--|--|----------|--|--------------------------------------|--|--|--|--------------------------|--|--|--|----------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE KNOWN OF DEATH                      |  |          |  | 2b. DATE OF ESTIMATED DEATH          |  |  |  | 2c. DATE PRONOUNCED DEAD |  |  |  | 2d. HOUR |  |  |  |
| Francis George Wehner  |         |  |  |   |  |  |  | 3/ 21/19 86                                  |  |          |  | 3/ 21/19 86                          |  |  |  | 2:44 P M                 |  |  |  |          |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.                             |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| Male   | White   | 11 9 40  |  | 45 YRS.   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED  |  | WIDOWED                                      |  | DIVORCED |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |                          |  |  |  |          |  |  |  |
| Maryland   |         | U.S.A.   |  |   |  |  |  |  |  |          |  | Baltimore County, MD.                |  |  |  |                          |  |  |  |          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| English Council  |         | 3900 Myrtle Ave.   |  | Longshorman   |  | Local 333  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                          |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| Maryland   |         | Baltimore  |  | English Council   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 3900 Myrtle Avenue 21227                     |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| Andrew Wehner  |         | Elva Hamilton  |  |   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| NO   |         | 218-36-1523  |  | Susan Topolnicki  |  | 3900 Myrtle Ave. 21227   |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | Shotgun Wound of Head  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
|  |         |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
|  |         |  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
|  |         |  |  | (c)   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I |         |  |  |   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | self inflicted shotgun wound   |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK              |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | 3900 Myrtle Ave., Halethorpe, Balto. Co., Md.  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an  |         | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  | death resulted from:  |  | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |  | DATE SIGNED   |  | 3/22/86  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |  |   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| Gregory R. Kauffman, M.D.  |         | 111 Penn St.   |  |   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  | COUNTY                                       |  | STATE    |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| Burial   |         | 3/25/86  |  | Loudon Park Cemetery  |  | Baltimore  |  |  |  | Maryland |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |
| Hubbard Funeral Home, Inc.   |         | MAR 24 1986  |  |   |  |  |  |  |  |          |  |                                      |  |  |  |                          |  |  |  |          |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM BW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

00-015-00

00-015-00



063048

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 8 4

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM J. WEICHSELDORFER SR.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3-5-86</b> |   |  | 2b. HOUR<br>45<br><b>1 P.M.</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-22-04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lowson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Foreman</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>G &amp; E Co.</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2811 FLEETWOOD AVE 21214</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Weichseldorfer</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Matilda Schranck</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-3167</b>  |  | 17. INFORMANT<br><b>21214</b> ADDRESS<br><b>2811 Fleetwood Ave.</b><br><b>Elizabeth M. Weichseldorfer</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL INFARCTION, LEFT</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>MIDDLE CEREBRAL ARTERY BRANCH</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATRIAL FIBRILLATION</b><br><b>ACCU D</b> |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>8713 HARFORD RD. BALTIMORE MARYLAND</b>   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/28</b> 19 <b>86</b> to <b>3/5</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/5/86</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Fausto Q. Aquino MD</b>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>3-5-86</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FAUSTO Q. AQUINO JR MD</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>8713 HARFORD RD. BALTIMORE MD 21234</b>                                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Mar 8 1986</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 6 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

RECEIVED

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

NOV 1964

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NOV 1964

072053

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |   |   |   |   |  |   |  |
|---|--|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>NETTIE WEISMAN</b>                            |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MARCH 9, 1986</b> |   |   | 2b. HOUR<br><b>6:40A</b> M  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 1, 1917</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6 CLEAR SKYS CT., APT. 101 (21209)</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                         |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |   |   |   |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6 CLEAR SKYS CT., APT. 101 (21209)</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM DOULL</b>                          |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA FLAX</b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>       |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>183-05-2080</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Larry Weisman 6 Clear Skys Ct (21209)</b>  |   |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Carcinoma of the Breast**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2110 3/9 86</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC)      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2110</b> , 19 <b>86</b> , to <b>3/9</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/9</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Sheldon Goldgeier</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>March 9, 1986</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SHELDON GOLDGEIER</b>  |  |   |  | 22e. ADDRESS<br><b>711 W 40<sup>th</sup> Street BALTIMORE 21201</b>   |  |   |  |

MEDICAL CERTIFICATION

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>REMOVAL/BURIAL</b>   |  | 23b. DATE<br><b>3/10/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. LEBANON CEM</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PHILADELPHIA PENNSYLVANIA</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b> |  |                             |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAR 11 1986</b>                             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove certificates, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

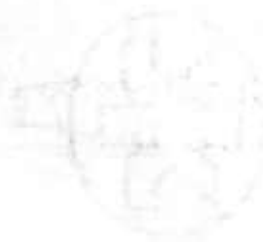
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

800570

2000 COLLECTIBLES

2000



2000

2000

2000

0-02045

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8607186

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |  |  |   |  |
|---|--|--|---|---|--|---|--|--|--|---|--|
| 1- DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM JOHN Welsh</b>                     |  |  | 2a. DATE OF DEATH<br>MONTH <b>03</b> DAY <b>23</b> YEAR <b>86</b> |   |  | 2b. HOUR<br><b>7:00 AM</b>  |  |  |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>JULY 29, 1937   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b>   |  | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>             |  | IF UNDER 24 HRS<br>HOURS <b>00</b> MIN. <b>00</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                          |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>GMC 6701 N. CHARLES STREET</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Counselor</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MD. Rehabilitation</b> |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |   |   |  |   |  |  |  |   |  |
| 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2301 Pentland Rd. 21234</b>                            |  |  |  |   |  |
| 14 FATHER'S NAME<br>FIRST <b>Charles Patrick</b> MIDDLE <b>Welsh</b> LAST         |  |  |   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Anne</b> MIDDLE <b>O'Donnell</b> LAST                   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>220-30-5495</b>  |  | 17 INFORMANT<br><b>Mary Anne Lund</b> ADDRESS<br><b>92 Dunkirk Rd. Baltimore, Md. 21212</b> |  |  |  |   |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **CARDIORESPIRATORY ARREST**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF  
(b) **SEPSIS**  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**1 WEEK**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:1a

**QUADRIPLÉGIA, END STAGE RENAL DISEASE**

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/20</b> , 19 <b>86</b> , to <b>3/23</b> , 19 <b>86</b> , that (I) (we) last<br>saw the deceased alive on <b>3/23</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Alan R. Malouf</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/23/86</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>alan Malouf M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>GMC 6701 N. Charles Street, Towson Md</b>   |  |   |  |

|   |  |                                    |  |  |  |   |  |
|---|--|------------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>March 26, 1986</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto. Co., Md.</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc.</b> ADDRESS<br><b>6500 York Rd. Balto., Md. 21212</b> |  |                                    |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 26 1986</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Rendell</b>                       |  |

21082-0

00-01963

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86

07187

REG. NO.

|  |  |   |   |   |                            |  |
|--|--|---|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Nannie B West</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 31 86</b> |   | 2b. HOUR<br>M<br><b>AM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 2 19</b>   |                            |  |
| 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>67</b> YRS   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   |   | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  | 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   | 13. STREET ADDRESS / ZIP CODE<br><b>Ave 21215 5519 Kennison Apt F</b>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harvey Gray</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fda Gross</b>   |   | 16. SOCIAL SECURITY NO.<br><b>212-28-3314</b>   |                            |  |
| 17. INFORMANT<br><b>Alonzo West</b>  |  | 18. ADDRESS<br><b>5519 Kennison Avenue</b>  |   | 19. DATE OF OPERATION   |                            |  |
| 20a. DATE OF OPERATION   |  | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |  |
| 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7-8 1986</b>  |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>7-8 1986</b> to <b>3-31 1986</b> that (I) (we) last saw the deceased alive on <b>3-31 1986</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br><b>MD [Signature]</b>   |                            |  |
| 22c. DEGREE  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MD [Signature]</b>  |   | 22e. ADDRESS<br><b>5400 OLD COURT RD</b>  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>4-1-86</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem Park</b>  |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville Md</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William C. March F. H. West 4300 Wabash Ave</b>  |   | 25a. DATE REC'D BY REGISTRAR<br><b>APR 01 1986</b>  |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  | 25c. REGISTRAR'S NAME<br><b>John Davidson-Randall</b>   |   | 25d. REGISTRAR'S ADDRESS  |                            |  |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Stroke**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **ASCVD**

DUE TO, OR AS A CONSEQUENCE OF

(c) **B**APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
**1 Month**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

201-10-00





072173

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 8 8

REG. NO.

|   |  |  |  |  |   |  |  |   |  |
|---|--|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Florence A. Wheat</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 9 86</b>                       |  |   | 2b. HOUR<br><b>9:50 a.m.</b>   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 13, 1938</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.  |  |   |  |
| 12. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nursing Home, Catonsville</b> |  |  |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cashier</b>  |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Credit Union</b>   |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br><b>Maryland</b>  |  |  | 16b. CITY OR TOWN<br><b>Baltimore</b>                                      |  | 16c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 17. STREET ADDRESS / ZIP CODE<br><b>1401 Marshall St. Balto. Md. 21230</b>         |   |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William ---- Clark</b>   |  |  | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Evelyn Mace Roesch</b> |  |   |  |  |   |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 21. SOCIAL SECURITY NO.<br><b>219-26-1330</b>  |  | 22. INFORMANT ADDRESS<br><b>Mr. Charles F. Wheat, Sr. Same as above</b>  |   |  |  |   |  |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTIC -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>BRAIN TUMOR (Glioma)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |   |  |  |   |  |
| 24. DATE OF OPERATION<br><b>4/17</b>  |  |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |   | 26. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 29. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>           |  |   | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 31. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 32. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |  |   | 33. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 34. I certify that (I) (this hospital) attended the deceased from <b>4/17</b> 19 <b>86</b> to <b>3/9</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/7</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.                 |  |  |  |  |   |  |  |   |  |
| 35. SIGNATURE<br><b>John Shaw</b>   |  |  | 36. DEGREE<br><b>MD</b>  |  |   | 37. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 38. DATE SIGNED<br><b>3/9/86</b>  |  |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Shaw</b>  |  |  | 40. ADDRESS<br><b>5800 Edmonson Ave 21228</b>                              |  |   |  |  |   |  |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 42. DATE<br><b>Mar. 12, 1986</b>   |  | 43. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>                                |  | 44. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Co. Maryland</b> |   |  |
| 45. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>  |  |  | 46. ADDRESS<br><b>21230</b>  |  | 47. DATE REC'D. BY REGISTRAR<br><b>MAR 10 1986</b>  |  | 48. REGISTRAR'S SIGNATURE<br><b>Handell</b>  |   |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "UNITED STATES" and "OFFICE" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

070040

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07189

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MAMIE WHEELER</b>  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR 3-3-86 7b HOUR 5:40 P.M.  |  |   |  |
| 3 SEX <b>F</b>   |  | 4 RACE <b>W</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR 3 3 1990   |  | 6 AGE (IN YEARS LAST BIRTHDAY) 96 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS HOURS MIN.                             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto Cal</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH <b>Catonsville</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bland Bryant Nursing Center</b> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>—</b>   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>MD</b> 13c COUNTY <b>Baltimore</b> 13d CITY OR TOWN <b>Baltimore</b> 13e INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13 STREET ADDRESS / ZIP CODE <b>918 N Fulton Street 21217</b>   |  |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b SOCIAL SECURITY NO. <b>219-54-3467</b>   |  | 17 INFORMANT ADDRESS <b>Spring Grove Hospital Center</b> <b>Mrs. Roscoe, Social Worker</b> <b>21228</b>   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.V.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>   |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-20-1977</b> to <b>3-3-1986</b> , that (I) (we) last saw the deceased alive on <b>3-3-1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>H. Deradoss M.D.</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED <b>3.3.86</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Deradoss M.D.</b>  |  |  |  | 22e. ADDRESS <b>BB Nursing Home</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>03-06-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. MD</b>   |  |
| 24. FUNERAL DIRECTOR <b>MacNabb Funeral Home, Catonsville, MD</b>  |  |  |  | 25a DATE REC'D. BY REGISTRAR <b>MAR 7 1986</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>   |  |

UNCLASSIFIED  
DATE 10-10-2000 BY SP-10/2000

010070



0-00541

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07190

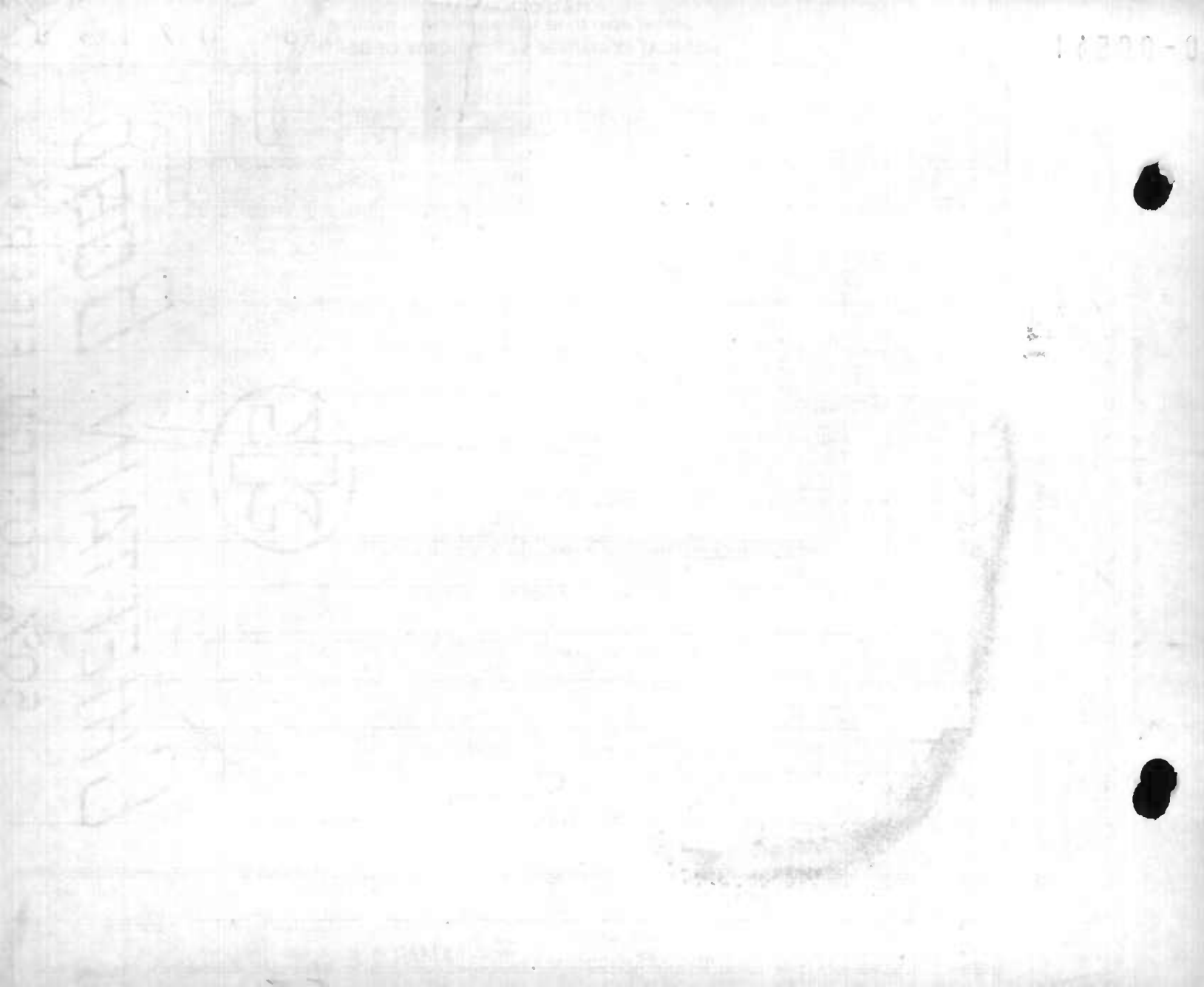
FOR  
1- STATE  
REGISTRAR

|   |         |   |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
|---|---------|---|--|---|--|---|--|---|--|--------------------------------|--|--------------------------------------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |  | MONTH                          |  | DAY                                  |  | YEAR |  | 2b. HOUR |  |
| Sampson   |         |   |  |   |  | Wheeler, III  |  |   |  | 3-15                           |  | 1986                                 |  |      |  | M        |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                          |  | 7c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH                                |  | DAY  |  | YEAR     |  |
| Male  | Balc k  | Sept 26, 64   |  | 21 YRS.   |  |   |  |   |  | 3-15                           |  | 1986                                 |  |      |  | 5:00 M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED                                   |  | DIVORCED                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |      |  |          |  |
| Maryland  |         | U.S.A.  |  |   |  |   |  |   |  |                                |  | Baltimore County,                    |  |      |  | MD       |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |                                |  |                                      |  |      |  |          |  |
|   |         | 8600 blk. Park Heights Avenue   |  | Carpenter's Helper  |  | 0   |  |   |  |                                |  |                                      |  |      |  |          |  |
| 13a. STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                       |  |                                |  |                                      |  |      |  |          |  |
| Md  |         | None  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3807 W. Rogers St.                        |  | 21215                          |  |                                      |  |      |  |          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| Sampson Wheeler, Jr.  |         | Laura Mathis  |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                                |  |                                      |  |      |  |          |  |
| None  |         | none  |  | Sampson Wheeler, Jr   |  | 3807 W. Rogers. Ave.  |  |   |  |                                |  |                                      |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:                            |         | IMMEDIATE CAUSE (a)   |  | Craniocerebral Trauma   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |   |  |                                |  |                                      |  |      |  |          |  |
| 7 8150  |         | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |         | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
|   |         | (c)   |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |         |   |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                                |  |                                      |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH      |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
|   |         | 2:00XX 3-15 1986  |  | driver in auto/fixed object impact  |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK             |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
|   |         | road  |  | 8600 blk. Park Heights Avenue, Balto. Co., Md                                 |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on   |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| death resulted from:  |         | Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  | 3-15-86   |  |   |  |                                |  |                                      |  |      |  |          |  |
| Dennis F. Smyth, M.D.   |         | Assistant   |  |   |  |   |  |   |  |                                |  |                                      |  |      |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         | ADDRESS   |  | 111 Penn St., Balto., Md.   |  | 21201   |  |   |  |                                |  |                                      |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |   |  |                                |  |                                      |  |      |  |          |  |
| Burial  |         | 3/21/86   |  | Arbutus Mem Park  |  | Baltimore, Maryland   |  |   |  |                                |  |                                      |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME  |         | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                |  |                                      |  |      |  |          |  |
| Law Funeral Home  |         | 4611 Park Heights Ave.  |  | 21215   |  | MAR 18 1986   |  |   |  |                                |  |                                      |  |      |  |          |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))



070110

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 9 1

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOROTHY A. WHIPPO</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>MARCH 5, 1986</b>                             |   |  | 2b. HOUR<br><b>10:45 A</b>   |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>JUNE 21, 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VALLEY VIEW NURSING HOME</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b>  |  |  | 13b. COUNTY <b>BALTIMORE</b>   |   | 13c. CITY OR TOWN <b>PARKVILLE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>JOHN C. MYERS</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>LAURA EYER</b>                      |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2914 PUTTY HILL AVE. 21234</b>                  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) <b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213015815B</b>  |   | 17. INFORMANT<br><b>FAMILY RECORDS</b>   |  |   |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia and Cachexia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Senile Dementia 2° Atherosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>48 hours</b> |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Colon-sacral fistula - Colostomy - severe Sacral Ulceration</b>   |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>Jan 86</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>absc fistula + ulceration</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTE IN MEDICAL EXAMINER'S REPORT)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NON-EMERGENCY <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, PARK, OFFICE, FARM, ETC.)                  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Jan 78 Mar 86</b>      |  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from above, (2) (this hospital) did not, and the body died death.  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Frank T. Kasik, Jr.</b>   |  |  | DEGREE   |   |  | 22c. DATE SIGNED<br><b>MARCH 7, 1986</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. FRANK T. KASIK, JR.</b>  |  |  | 23b. ADDRESS<br><b>9005 HARFORD ROAD - PARKVILLE</b>                                 |   |  |  |   |  |  |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23d. DATE<br><b>3-8-1986</b>   |   | 23e. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND M.S.M.</b>                   |  | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MARYLAND</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS CHAPL OF MEMORIES HARFORD</b>   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 7 1986</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |  |   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

BP



88 WWP



072047

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07192

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Mary N. WHITFIELD</i>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>3-9-86</i>   |  | 2b. HOUR<br><i>1:35</i> M.  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 9 32</i>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>53</i> YRS.  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore County General</i>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Catalyst Research Corp.</i>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>21207</i>  |  | 13a. STATE<br><i>Md</i>  |  | 13b. COUNTY<br><i>Balto</i>   |  |
| 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><i>3137 Timanus Lane</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Albert L. Whitfield</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Esther T. Trusdale</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>239-46-5862</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Albert L. Whitfield 3137 Timanus Lane</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>INTRACEREBRAL HEMORRHAGE</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><i>HYPERTENSION; ADULT RESPIRATORY DISTRESS SYNDROME</i>   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>3-9-86</i> P.M. <i>19</i>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22. I certify that (I) (this hospital) attended the deceased from <i>3-9-86</i> to <i>3-9-86</i> , that (I) (we) last saw the deceased alive on <i>3-9-86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22a. SIGNATURE<br><i>[Signature]</i>   |  | DEGREE   |  | 22b. DATE SIGNED<br><i>3-9-86</i>   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ORLANDO B. CONNAN MD.</i>  |  | 22d. ADDRESS<br><i>BECH-RANDALL ST NW MD. 21133</i>  |  | 22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>3-13-86</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Baltimore Cemetery</i>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Md</i>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>William C. March F.H. West 4300 Wabash Ave</i>  |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><i>MAR 11 1986</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ROBERT M. W. BIRCH

CHIEF OF POLICE

00-0.0273

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 9 3

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ESTELLE MAY WILLIAMSON   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 11, 1986 |   |  | 2b. HOUR<br>10:15A.M.   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 2, 1885   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>100 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Home |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1550 Langford Road 21207   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Bevan  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Georgia Herbert  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-26-9865   |   | 17. INFORMANT<br>ADDRESS<br>419 Rosecroft Terrace<br>Elizabeth Phillips Baltimore, MD. 21229  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>100 yrs old</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Cover &amp; Cress Hotel &amp; Restaurant</u>   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>9/22</u> , 19 <u>72</u> , to <u>3/11</u> , 19 <u>86</u> , that (I) <u>last</u> saw the deceased alive on <u>2/20</u> , 19 <u>86</u> , and that in <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(certified)</u> (did not) view the body after death.                               |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Cliff Ratliff Jr.</u>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>3/11/86  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Cliff Ratliff Jr. M.D.   |  |  |   | 22e. ADDRESS<br>5772 Westview Mall, Baltimore, MD.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3/14/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, MD. 21228  |  |  |   | 25. DATE REC'D. BY REGISTRAR<br>MAR 14 1986   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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071049

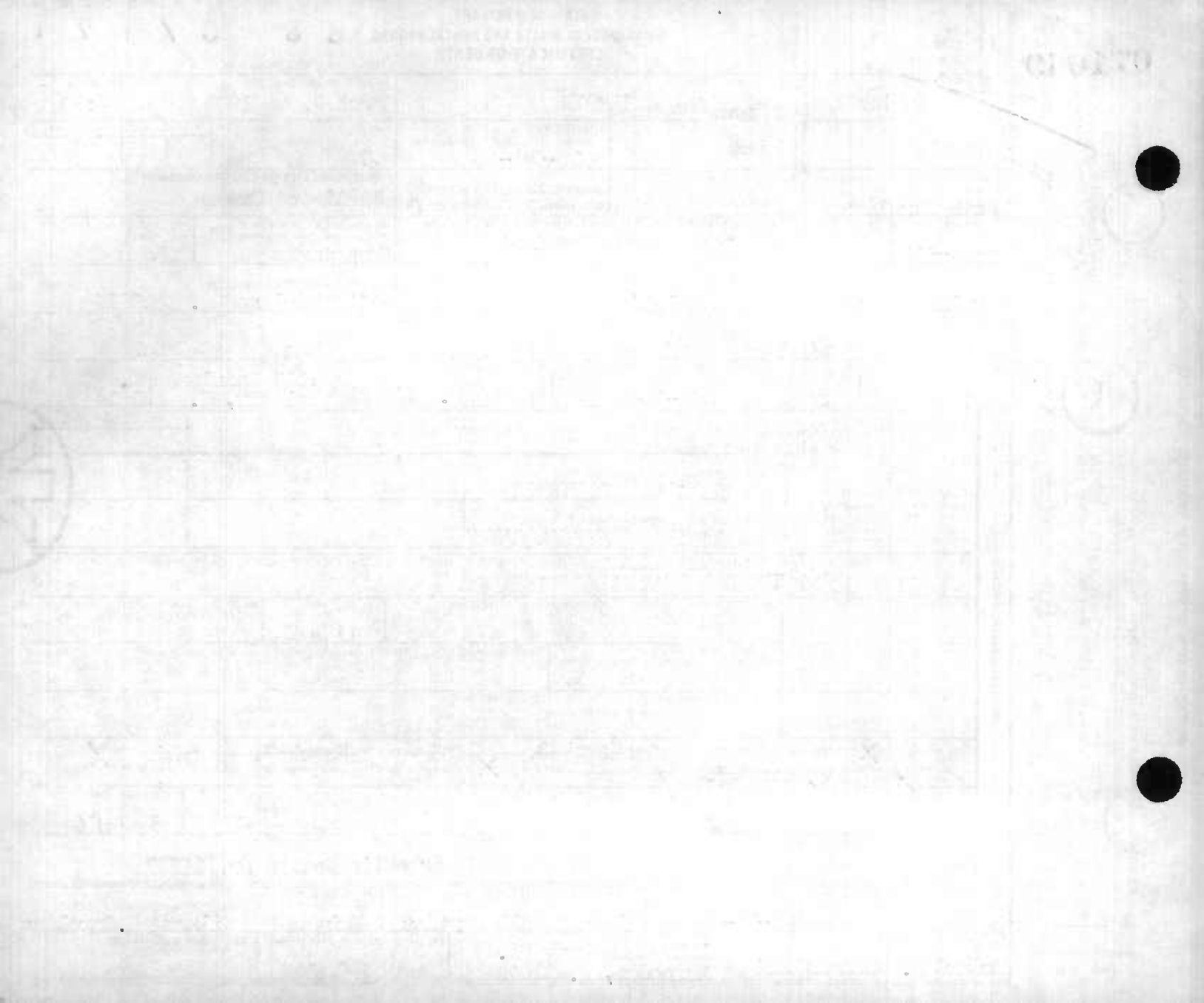
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07194

REG. NO.

|  |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR P M  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  |  | March 7, 1986  |  |  |  | 4:20 P M  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Female   |  | White  |  | 10-30-15   |  | 70   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| North Carolina   |  | USA  |  |  |  | Baltimore County MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Rossville  |  | Franklin Square Hospital   |  |  |  | Seamstress   |  | Shoes   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE  |  |  |  |
| Maryland Harford   |  |  |  | Bel Air  |  |  |  | 2117 Fairlane Rd. 21014   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| Noah Winfrey Luffman   |  |  |  | Rosa Jane Couch  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| No   |  | None   |  | 245-34-9529  |  | Robert T. Wilmoth  |  | 2117 Fairlane Rd. Bel Air, Md. 21014  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO: OR AS A CONSEQUENCE OF (b) CARDIAC ARRHYTHMIA  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO: OR AS A CONSEQUENCE OF (c) ANOXIC ENCEPHALOPATHY   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE   |  |  |  |  |  |  |  |   |  |  |  |
| 9a. DATE OF OPERATION  |  | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 3, 1986, to March 7, 1986, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death, 1986, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
|  |  |  |  |  |  |  |  | 3-7-86  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| Lee Joon Loh   |  |  |  | 9000 Franklin Square Dr., 21237  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial   |  | 3-11-86  |  | Plesant Hill Baptist   |  | Elkin Wilkes N. Carolina   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 1317. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| Howard K. McComas III  |  | Abingdon, Md. 21009  |  | MAR 10 1986  |  |  |  |   |  |  |  |

MEDICAL CERTIFICATION



001801

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies Pages 1 and 2 and file with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |   |                                   | REG. NO.                                     |  |
|---|--|--|--|---|---|---|--|---|-----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>WILLIAM R WINDSOR   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>3 27 86 |   |  | 2b. HOUR<br>4 A M   |                                   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 24, 1908  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS   |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |                                   | 7b. IF UNDER 24 HRS HOURS MIN.               |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                                   |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore County Gen. Hospital |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor, State Highway Adm. |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Sykesville  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>7503 Gaither Rd. 21784  |  |   |                                   |  |  |
| FATHER'S NAME FIRST MIDDLE LAST<br>Randolph H. Windsor  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ida P. Burdette   |   |   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217-34-0344  |  | 17. INFORMANT ADDRESS<br>2320 So. Dolphin Ave.<br>Mrs Ann Thompson, Middleburg, Fl. 32066   |   |   |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis from u.t.i. Metastatic disease<br>DUE TO, OR AS A CONSEQUENCE OF (b) dehydration<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |   |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |  |  |   |   |   |  |   |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                               |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |   |  |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-6 19 86 to 3-27 19 86, that (I) (we) lost saw the deceased alive on 3-27 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I) did not view the body after death.   |  |  |  |   |   |   |  |   |                                   |  |  |
| 22b. SIGNATURE<br>Rajadurga Govinda Rao   |  |  |  | DEGREE<br>MD  |   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br>3-27-86                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAJADURGA GOVINDA RAO  |  |  |  | 22e. ADDRESS<br>Baltimore County Gen Hospital   |   |   |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Mar. 29, 1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Rockville, Montgomery, Md.                           |  |   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>Otis L. Molesworth, P.A., Damascus, Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 31 1986  |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |                                   |  |  |

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00-01090

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 07196

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |                                    |   |  |  |
|--|--|--|---|--|------------------------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |                                    | 2b. HOUR  |  |  |
| ESTHER BLAIR WINN  |  |  | 3-19-86   |  |                                    | 7:25 PM   |  |  |
| 3. SEX   |  |  | 4. RACE   |  |                                    | 5. DATE OF BIRTH  |  |  |
| FEMALE   |  |  | WHITE   |  |                                    | MONTH DAY YEAR<br>11 4 08   |  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| Pennsylvania   |  |  | U.S.A.  |  |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |
| CITY OR TOWN OF DEATH  |  |  | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |
| Randallstown   |  |  | Baltimore County General Hosp.  |  |                                    | Supervisor-Nurse Nursing  |  |  |
| 10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 11. CITY OR TOWN  |  |                                    | 13a. STREET ADDRESS / ZIP CODE  |  |  |
| Maryland   |  |  | Baltimore   |  |                                    | 2607 Northshire Dr. 21230   |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                    | 17. INFORMANT   |  |  |
| George   |  |  | Ann   |  |                                    | Johnson   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |                                    | 17. ADDRESS   |  |  |
| NO   |  |  | 220-30-7383   |  |                                    | George H. Kinkel 3801 Washington Ave. 21207   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |   |  |                                    |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |                                    |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                    | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |  |  |   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-13</u> , 19 <u>86</u> , to <u>3-19</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3-19</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |   |  |                                    |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |   |  |                                    | DEGREE<br><u>MD</u>   |  | 22c. DATE SIGNED<br><u>3-19-86</u>                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>R. DEPESTRE</u>  |  |  |   |  |                                    | 22e. ADDRESS<br><u>BALTIMORE COUNTY GENERAL HOSPITAL</u>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial   |  |  | 3/24/86   |  | Meadowridge Mem. Pk.               |   | Elkridge Howard Maryland                   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |  |   |  |                                    | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |  |  |   |  |                                    | 21229<br>MAR 21 1986  |  | <u>[Signature]</u>   |

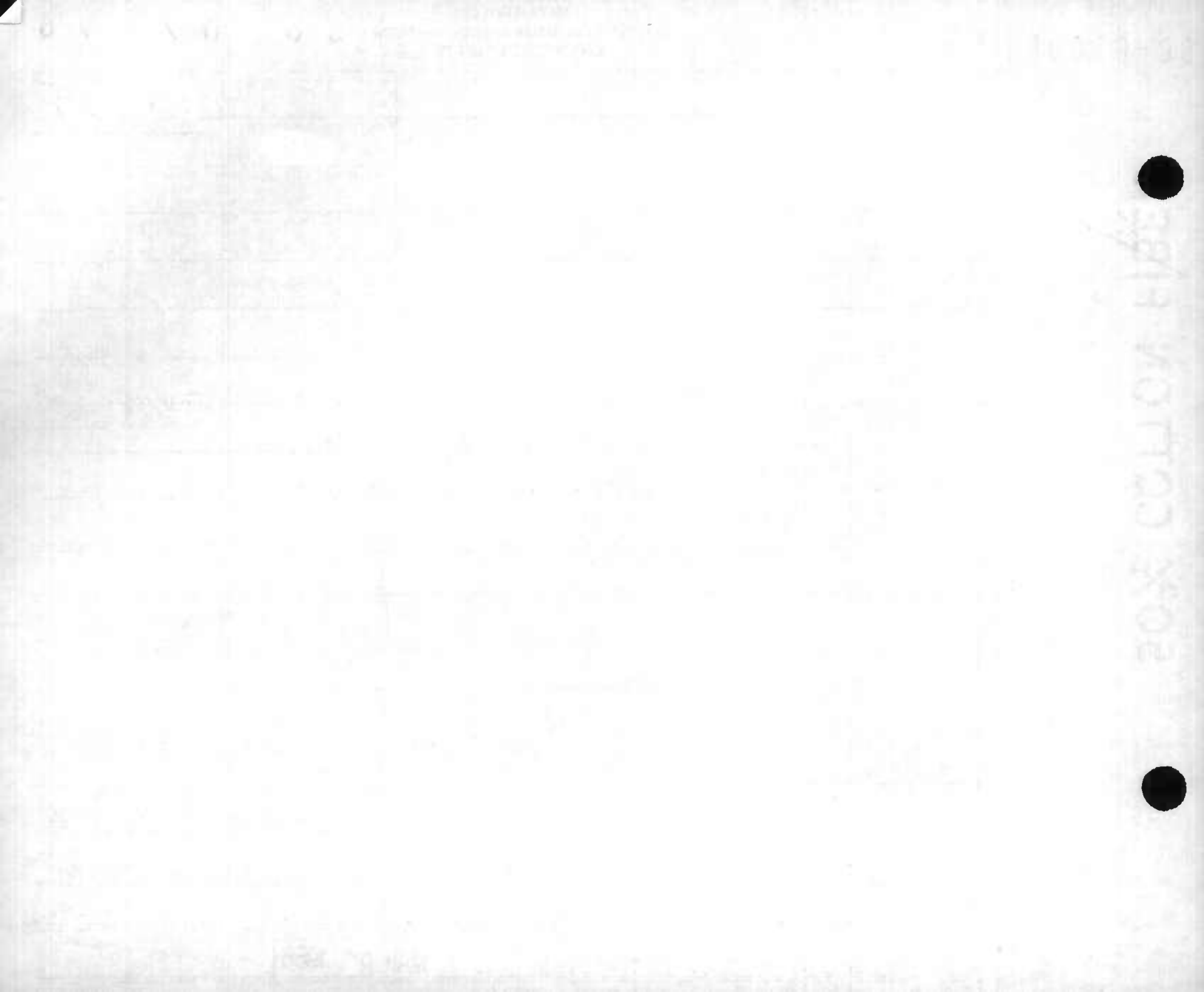
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner should not sign this certificate.



00-00112

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 9 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NICHOLAS V. Wittway  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MARCH 8, 1986   |  | 2b. HOUR<br>M   |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 06 04   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82<br>YRS. MONTHS DAYS HOURS MIN.           |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>COUNTY MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Dependent                      | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br>Md  |   |   | 13b. COUNTY<br>Balto.  | 13c. CITY OR TOWN<br>Essex   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wittway   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>none   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Carolyn A. Eldridge 221 Alpine Rd.            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><u>Michael Schwartz</u>   |   | DEGREE  |  | 22c. DATE SIGNED<br>3/10/86.   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. MICHAEL SCHWARTZ   |   | 22e. ADDRESS<br>! Eastern Blvd. Essex, Maryland   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   | 23b. DATE<br>Mar. 12, 1986  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville Balto. Md.           |   |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Baltimore, Maryland  |   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>MAR 13 1986 <u>John Landon Hendall</u> |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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00-00680

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 1.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8607198

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |   |  |  |  |  |  |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jesse</b>  |  | FIRST <b>B.</b>   |  | MIDDLE <b>WOLF</b>   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH <b>3</b> DAY <b>12</b> YEAR <b>86</b>   |  | 2b. HOUR<br><b>545</b> AM  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>20</b> YEAR <b>01</b>  |  | 6 AGE (IN YEARS (LAST BIRTHDAY))<br><b>84</b> YRS                                       |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. TOWSON</b> County <b>MD.</b>           |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dulaney Towson Nursing Center</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.-Optician</b> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Universal Opt</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>340 Elinor Avenue 21236</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Clinton</b> MIDDLE <b>M.</b> LAST <b>Wolf</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Josephine</b> MIDDLE <b></b> LAST <b>Hamlin</b>   |  |   |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b SOCIAL SECURITY NO.<br><b>216-07-7337</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Mrs. Eileen A. Bowers 340 Elinor Ave. 21236</b>           |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Recent CVA</b><br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF <b></b><br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>5+ yrs</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)          |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>10 March 86</b> to <b>12 March 86</b> , that (I) (we) last saw the deceased alive on <b>11 March 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not view the body after death).   |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Charles O'Donnell</b>  |  |   |  | DEGREE<br><b></b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/13/86</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles O'Donnell, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>(823-3161) 7501 York Rd. Towson, Md. 21204</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   |  | 23b. DATE<br><b>3-14-86</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                       |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Lassahn Funeral Home</b>   |  |   |  | 24b. ADDRESS<br><b>7401 Belmar Rd. BALTO. MD. 21236</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 17 1986</b>                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. J. J.</b>  |  |  |  |

BP

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR, FBI  
SUBJECT: [Illegible]

TO: [Illegible]  
FROM: [Illegible]  
DATE: [Illegible]  
RE: [Illegible]

[Illegible body text]

[Illegible body text]

00-02095

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 1 9 9

REG. NO.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br><small>(Type or Print)</small><br>Rose Riley Wolff  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3- 29-86   |   | 2b. HOUR<br>5:50a <sub>MD</sub>  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3/27/23   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 23 HRS<br>HOURS MIN.        |  |
| 7a. BIRTHPLACE<br><small>(STATE OR FOREIGN COUNTRY)</small><br>England  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small><br>3239 E. Joppa Rd. |   | 12a. USUAL OCCUPATION<br><small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small><br>Bar Owner  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Business                         |  |
| 13a. USUAL RESIDENCE <small>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)</small><br>Md.  |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br><small>FIRST MIDDLE LAST</small><br>William Riley  |   | 15. MOTHER'S MAIDEN NAME<br><small>FIRST MIDDLE LAST</small><br>unknown   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><small>(YES, NO OR UNKNOWN)</small><br>No   | 16b. SOCIAL SECURITY NO.<br><small>(IF YES, GIVE WAR OR DATES)</small><br>--  | 17. INFORMANT<br>Barry Stansbury, same as above   |   |   |  |
| 18. CAUSE OF DEATH <small>Enter only one cause per line for (a), (b), and (c)</small><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of larynx/breast/pancreas</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED <small>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)</small> |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br><small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2</u> , 19 <u>86</u> , to <u>3/29</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>3/27</u> , 19 <u>86</u> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we said "did not see the body after death," circle "X" above.)  |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Kendall Faulkner MD</u>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>3/29/86   |  |
| 22d. PHYSICIAN'S NAME <small>(TYPE OR PRINT)</small><br>Dr. Kendall Faulkner  |   | 22e. ADDRESS<br>5606 Pimlico Rd.  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><small>(SPECIFY)</small><br>Cremation  | 23b. DATE<br>3-31-86  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cem.   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD.                                      | 23e. DATE REC'D. BY REGISTRAR<br>APR 01 1986                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Schimunek Funeral Home, Inc.  |   | 9705 Belair Road 21236  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Rondelle</u>               |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 constitute a final report 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "did not see the body after death," circle "X" above.

BP \_\_\_\_\_





069033

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 2 0 0

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |   |  |  |                      |  |
|---|--|---|--|--|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Frank Lee WOODEN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 4, 1986         |  | 2b. HOUR<br>1205p.m. |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 24, 1911                                   |                      |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS   |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |                      |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Policeman        |                      |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. City PD   |  |   |  |  |                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |                      |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Overlea   |                      |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>6715 Linden Ave. 21206  |  |  |                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank L. Wooden   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ruth Wright |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-05-0829A   |  | 17. INFORMANT<br>ADDRESS<br>21206<br>Emma M. Wooden, 6715 Linden Ave.                |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>COPD</u><br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST. |  |   |  |  |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.   |  |   |  |  |                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                      |  |
| 22. I certify that (1) (this hospital) attended the deceased from <u>5. 28</u> 19 <u>82</u> to <u>3. 21</u> 19 <u>86</u> that (1) (we) last<br>saw the deceased alive on <u>3. 21. 86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) (did) (did not) (to) the body of the deceased.                               |  |   |  |  |                      |  |
| 22a. SIGNATURE<br><u>Anil Sanghera</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED<br>Mar. 5, 1986   |                      |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Anil Sanghera, M.D.  |  |   |  | 22e. ADDRESS<br>6919 Harford Rd.   |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Mar. 7, 1986   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                       |                      |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore  |  | COUNTY<br>Md.   |  | STATE  |                      |  |
| 24. FUNERAL DIRECTOR<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214   |  |   |  | 25. DATE RECD. BY REGISTRAR<br>MAR 6 1986  |                      |  |
|   |  |   |  | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                      |                      |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-01528

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 2 0 1

REG. NO.

|   |  |   |   |   |   |   |  |  |  |
|---|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Wilbur S. Worth   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>3 18 86                    |   |   | 2b. HOUR<br>M<br>A  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 15 1898   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Perry Hall   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>8906 Jasper Lane 21234 |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Superintendent              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FA Taylor Roof.             |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8906 Jasper Lane 21234         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Worth   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anne R. Bradford |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-03-0498  |   | 17. INFORMANT<br>ADDRESS<br>Bonnie J. Bruff 8906 Jasper Lane 21234  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Ischemic Cardiomyopathy<br>DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Atherosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br>COPD  |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |  |  |  |
| 22a. SIGNATURE<br>Gracito Patricio, MD (254-0392)   |  |   |   | 22b. ADDRESS<br>2926 Cold Spring Lane Baltimore, Maryland   |   |   |  | 22c. DATE SIGNED<br>3/18/86                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>3-21-86  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home BALTO. MD. 21234   |  |   |   | 25a. DATE REG'D. BY REGISTRAR<br>MAR 24 1986  |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson   |  |  |  |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corresponding pages (read 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal). IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 606-555-1234.

BP

The above is a copy of the  
 original document.

100

00-00666

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 07202

1- FOR  
STATE  
REGISTRAR

|   |         |                  |  |                   |                    |   |  |  |   |       |      |   |          |
|---|---------|------------------|--|-------------------|--------------------|---|--|--|---|-------|------|---|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |                  | FIRST  | MIDDLE            | LAST               | 2a. DATE KNOWN<br>OF DEATH  |  |  | ESTI-<br>MATED  | MONTH | DAY  | YEAR  | 2b. HOUR |
| ERNEST HILTON WRIGHT SR.  |         |                  |  |                   |                    | 3. DATE OF DEATH  |  |  | 3   | 18    | 86   | M   |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | 7. IF UNDER 1 YR. | 8. IF UNDER 2 HRS. | 2c. DATE<br>PRONOUNCED<br>DEAD  |  |  | MONTH   | DAY   | YEAR | 2d. HOUR  |          |
| M   | W       | 6/17/26          | 59 YRS.  |                   |                    | 3   |  |  | 18  | 86    | 19   | 0800  |          |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                   |                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |       |      |   |          |
| New Jersey  |         |                  | USA  |                   |                    |   |  |  | Baltimore County MD.  |       |      |   |          |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   |                    | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |       |      |   |          |
| Stevenson   |         |                  | 2201 Green Spring Valley Rd.   |                   |                    | Executive -- Construction   |  |  |   |       |      |   |          |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         |                  | 13b. COUNTY  |                   |                    | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |       |      |   |          |
| MD  |         |                  | Balto.   |                   |                    | Stevenson   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |       |      |   |          |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME   |                   |                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |       |      | 17. INFORMANT   |          |
| Edward Barhyte Wright   |         |                  | Dorothy Bull   |                   |                    | Yes   |  |  | 212 26 3290   |       |      | Charlotte S. Wright, Same   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |                  |  |                   |                    |   |  |  |   |       |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Immediate</u> |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |                  |  |                   |                    |   |  |  |   |       |      |   |          |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                   |                    |   |  |  |   |       |      | 20. AUTOPSY?  |          |
|   |         |                  |  |                   |                    |   |  |  |   |       |      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   |                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |       |      |   |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                   |                    | 21f. LOCATION<br>STREET   |  |  | CITY OR TOWN  |       |      | COUNTY STATE  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |                  |  |                   |                    |   |  |  |   |       |      |   |          |
| ACTUAL<br>SIGNATURE   |         |                  | TITLE (SPECIFY)  |                   |                    | DATE<br>SIGNED  |  |  |   |       |      |   |          |
| <i>Stanley Z. Felsenberg</i>  |         |                  | M.D. Deputy  |                   |                    | MEDICAL EXAMINER  |  |  | 3/18/86   |       |      |   |          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |         |                  | ADDRESS  |                   |                    |   |  |  |   |       |      |   |          |
| Stanley Z. Felsenberg M.D.  |         |                  | 11 E. Chase St.  |                   |                    | 21202   |  |  |   |       |      |   |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         |                  | 23b. DATE  |                   |                    | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN                                       |       |      |   |          |
| Cremation   |         |                  | 3/19/86  |                   |                    | Green Mount   |  |  | Balto., MD  |       |      |   |          |
| 24. FUNERAL DIRECTOR<br>NAME  |         |                  | 25a. DATE REC'D. BY REGISTRAR  |                   |                    | 25b. REGISTRAR'S SIGNATURE  |  |  |   |       |      |   |          |
| Henry W. Jenkins & Sons Co.   |         |                  | 4905 York Road Balto., MD 21212  |                   |                    | <i>John Davidson</i>  |  |  |   |       |      |   |          |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | 8 6 0 7 2 0 3  |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |  |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Lillie H. Yakubowski   |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 31, 1986  |  | 2b. HOUR<br>5:45 A.M.  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 07, 1909  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>77 YRS   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. Co. MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Valley Nursing and Convul Home |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machine Oper   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bolt & Nut                                      |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md  |  |   |  | 13b. COUNTY<br>Balto. Co.  |  | 13c. CITY OR TOWN<br>Towson  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>8720 Enge Road 21234   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Smith  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bronsilana Lipniski   |  |  |  | 16. ADDRESS<br>Baltimore Md 21239  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>230-24-8382   |  | 17. INFORMANT<br>Mr. John Yakubowski   |  |  |  | 916 Overbrook Road   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ischemic coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Dr. Marion Kowalewski   |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>4-1-86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Marion Kowalewski  |  |   |  |  |  | 22e. ADDRESS<br>8604 Harford Road Balto., Md.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial;   |  |   |  | 23b. DATE<br>04/03/86  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Balto. Co. Md              |  |  |  |
| 24. FUNERAL DIRECTOR<br>Burgee Henss Funeral Home, P.A. Baltimore 21211   |  |   |  |  |  | DATE REC'D. BY REGISTRAR<br>APR 01 1986  |  | 25. REGISTRAR'S SIGNATURE  |  |  |  |





070065

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 2 0 4

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hilda M YOST  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>March 5, 1986                   |   |  | 2b. HOUR<br>8:55 <sup>P</sup> <sub>M</sub>  |  |  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 07 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br>8425 AVERY RD. 21237   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY DOERING  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELIZABETH HOLMAN              |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>N/A   |  | 17. INFORMANT<br>RICHARD YOST   |  | ADDRESS<br>8425 AVERY ROAD  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MULTIPLE MYELOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 4, 1986, to March 5, 1986, saw the deceased alive on March 5, 1986, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>V. Ashley MD   |  |   | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>3/5/86   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Virginia ASHLEY MD,   |  |   |  |   | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237                                |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>3/08/86   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH                         |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Balto Md |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>[Signature]  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 7 1986                                    |   |  |  |  |
| ADDRESS<br>1241 Chesaca Ave.   |  |   |  |   | REGISTRAR'S SIGNATURE<br>John Davidson-Russell                                 |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8607205

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ETHEL Lenora YOUNG BLOOD</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>3/9/86</b> |   |  | 2b. HOUR<br><b>12:45 A.</b>  |  |
| 3. SEX<br><b>Femle</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6/16/99</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Inglebrook Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>               |  |
| 13a. STATE<br><b>Maryland</b>                                       |  | 13b. COUNTY<br><b>Prince George's</b>   |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 14. STREET ADDRESS / ZIP CODE<br><b>5831 31st Place 20782</b>      |  |
| 15. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adam Gurtler</b>       |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agatha Schaffer</b>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>YES <input type="checkbox"/> NO OR UNKNOWN <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)   |  |  |  |
| 17. SOCIAL SECURITY NO.<br><b>234-22-6693</b>                       |  | 18. INFORMANT<br>ADDRESS <b>5831 31st Place</b><br><b>Iva Lee Everett (Daughter) Hyattsville, Md.</b>                                       |   |   |  |  |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>SPICA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASLUD</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF OTHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 19 <b>86</b> to <b>3/9</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>3/8</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Mark Davis, M.D.</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>3/10/86</b>   |  |
| 22d. PHYSICIAN'S NAME (PRINT)<br><b>Mark Davis, M.D.</b>   |  | 22e. ADDRESS<br><b>9051 Baltimore Natl. Park<br/>Ellicott City, Maryland 21043</b> |  |  |  |  |  |

|   |  |                             |  |   |  |   |  |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Cremation</b>   |  | 23b. DATE<br><b>3/10/86</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria N/A Virginia</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Princo Gasch's Sons Funeral Home, P.A.<br/>4739 Baltimore Avenue Hyattsville, Maryland 20781</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 14 1986</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>W. W. Anderson</b> |  |

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TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use at the funeral home. Then please remove carbon papers, pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 (b) is marked, or other traumatic event, the medical examiner must be notified.

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20% COTTON FIBER

WILSON



WILSON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 0 7 2 0 6  
REG. NO.

FOR  
STATE  
REGISTRAR

00-02124

1- DECEASED NAME (TYPE OR PRINT) **William J. Zelenka**

2a DATE OF DEATH MONTH **3** DAY **27** YEAR **86** 2b HOUR **6 A.M.**

3 SEX **Male** 4 RACE **WHITE** 5 DATE OF BIRTH MONTH **12** DAY **5** YEAR **21**

6 AGE (IN YEARS, LAST BIRTHDAY) **64** YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) **USA - Md.** 7b CITIZEN OF WHAT COUNTRY? **U.S.A.** 8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH **Balto. Co.** MD.

10 CITY OR TOWN OF DEATH **Towson** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Manor Care-Towson**

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Computer Programmer** 12b KIND OF BUSINESS OR INDUSTRY **Soc. Sec.**

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE **Md.** 13b CITY OR TOWN **Baltimore** 13c INSIDE CITY LIMITS? YES ☒ NO ☐ 13d STREET ADDRESS / ZIP CODE **4355 Shamrock Ave. 21206**

14 FATHER'S NAME FIRST MIDDLE LAST **James Zelenka** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Lillian Blazek**

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **Yes** (IF YES, GIVE WAR OR DATES) **WW II** 16b SOCIAL SECURITY NO. **215-12-7565** 17 INFORMANT ADDRESS **Evelyn Zelenka (sister) same address**

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **metastatic colon cancer** APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH **2 years**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **10**

MEDICAL CERTIFICATION

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☐ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 **19** 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22. I certify that (I, this hospital) attended the deceased from **1/21** 19 **84**, to **3/27** 19 **86**, that (I/we) last saw the deceased alive on **3/17** 19 **86**, and that (I/we) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did (did not) view the body after death.

22b SIGNATURE **Dr. George Lowe** DEGREE **MD** ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c DATE SIGNED **3-31-86**

22d PHYSICIAN'S NAME (TYPE OR PRINT) **Dr. George Lowe** 22e ADDRESS **3703 Belair Rd.**

23a BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23b DATE **3/29/86** 23c NAME OF CEMETERY OR CREMATORY **Holy Redeemer** 23d LOCATION CITY OR TOWN **Baltimore** COUNTY **Md.** STATE

24 FUNERAL HOME OR NAME ADDRESS **Schmunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21218** 25a DATE REC'D. BY REGISTRAR **APR 01 1986** 25b REGISTRAR'S SIGNATURE **W. Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT ANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED

10-10-10

12-2-10

10-10-10



RECEIVED

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